EMERALD COAST CANCER CENTER

PLEASE VISIT OUR WEBSITE AT WWW.EMERALDCOASTCANCERCENTER.COM

1024 MAR WALT DRIVE
FT. WALTON BEACH, FL 32547

7720 HWY 98 WEST STE 240
DESTIN, FL 32550

NEW PATIENT INFORMATION FORM - PLEASE PRINT LEGIBLY - THANK YOU.

PATIENT'S NAME_____ DATE OF BIRTH_____/_____/_____

ADDRESS _____ TELEPHONE # _____-_____-_____HOME

_____ _____-_____-_____WORK

_____ SOCIAL SECURITY#_____-_____-_____

MALE OR FEMALE _____ TODAY'S DATE _____

PLACE OF WORK _____ EMPL.TEL#_____

INSURANCE INFORMATION

PRIMARY CARRIER_____ EMPLOYER_____

POLICY NUMBER_____ GROUP NUMBER_____

POLICY HOLDER NAME AND SSN _____

POLICY HOLDER DATE OF BIRTH_____

SECONDARY CARRIER_____ EMPLOYER_____

POLICY NUMBER_____ GROUP NUMBER_____

POLICY HOLDER NAME AND SSN _____

POLICY HOLDER DATE OF BIRTH_____

REFERRING DOCTOR TELEPHONE# ADDRESS (IF NOT LOCAL)
_____ _____ _____

OTHER DOCTORS
1._____ _____ _____

2._____ _____ _____

DESCRIBE YOUR CURRENT PROBLEM BRIEFLY IN YOUR OWN WORDS: WHAT BOTHERS YOU, HOWAND WHEN IT STARTED, ETC. & WHY YOU WERE REFERRED TO US:

_____

_____

_____

_____

DUE TO THE NATURE OF OUR SPECIALITY, WE REQUIRE A RATHER DETALIED HISTORY FROM OUR PATIENTS. THE INFORMATION REQUESTED BELOW WILL BE KEPT IN THE STRICTEST CONFIDENCE. PLEASE BE AS THOROUGH AS POSSIBLE SO THAT WE CAN PROVIDE YOU WITH THE BEST POSSIBLE CARE.

PLEASE LIST ALL OPERATIONS THAT YOU HAVE HAD, INCLUDING MINOR SURGERY:

OPERATION	DATE	SURGEON
OPERATION	DATE	SURGEON
OPERATION	DATE	SURGEON
OPERATION	DATE	SURGEON
OPERATION	DATE	SURGEON

HAVE YOU EVER HAD RADIATION THERAPY? IF SO, PLEASE LIST THE DATE AND AMOUNT OR DURATION OF THERAPY, THE BODY AREA RADIATED, AND THE NAME OF THE RADIOTHERAPY CENTER.

BODY AREA	DATE	DOSAGE	RT CENTER
BODY AREA	DATE	DOSAGE	RT CENTER

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: PRESCRIPTIONS, OVER THE COUNTER MEDICINES,VITAMINS, ETC.

MEDICATION NAME_____DOSE_____(MG) FREQUENCY_____
REASON TAKEN_____

MEDICATION NAME_____DOSE_____(MG) FREQUENCY_____
REASON TAKEN_____

MEDICATION NAME_____DOSE_____(MG) FREQUENCY_____
REASON TAKEN_____

MEDICATION NAME_____DOSE_____(MG) FREQUENCY_____
REASON TAKEN_____

MEDICATION NAME_____DOSE_____(MG) FREQUENCY_____
REASON TAKEN_____

PLEASE PROVIDE YOUR PHARMACY NAME AND PHONE NUMBER FOR OUR RECORDS
PHARMACY_____PHONE NUMBER_____

HAVE YOU EVER HAD AN ADVERSE REACTION OR ALLERGIC REACTION TO ANY MEDICATION OR FOOD? IF SO, PLEASE LIST THE AGENT AND DESCRIBE THE REATION. IF NOT, PLEASE WRITE NEVER.

LIST ANY MEDICAL PROBLEMS YOU HAVE NOW OR HAVE HAD IN THE PAST. (I.E. DIABETES, ULCER, HEART DISEASE, BLEEDING PROBLEMS)

ILLNESS	DATE OF ONSET	TREATING MD
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

HAVE YOU EVER BEEN TREATED WITH HORMONES? _____

WERE YOU EVER EXPOSED TO TOXIC CHEMICALS? _____

HAVE YOU TRAVELED OUTSIDE THE U.S.? _____ IF SO, WHERE? _____

HAVE YOU EVER HAD TUBERCULOSIS (TB) ?_____ HAS ANYONE CLOSE TO YOU EVER HAD TB?_____

HAVE YOU EVER HAD A PROBLEM WITH DRUGS OR ALCOHOL?_____
IF SO, DESCRIBE_____

DO YOU DRINK ALCOHOL NOW?_____ IF SO , HOW MUCH?_____

HAVE YOU EVER SMOKED?_____ IF SO, HOW MUCH?_____
HAVE YOU QUIT SMOKING?_____ WHEN?_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION?_____PLEASE DESCRIBE THE CIRCUMSTANCES_____

HAVE YOU EVER HAD A REACTION TO A BLOOD TRANSFUSION?_____

HAVE YOU EVER HAD PSYCHIATRIC TREATMENT OR HOSPITALIZATION?_____
IF YES, PLEASE DESCRIBE_____
_____

HAVE YOU EVER TAKEN PSYCHOACTIVE MEDICATIONS?_____
IF YES, PLEASE DESCRIBE_____

MARITAL STAUS : SINGLE _____ MARRIED _____ DIVORCED_____

SEPARATED_____WIDOW(ER)_____SIGNIFICANT OTHER_____LIFE PARTNER_____

DID YOU GRADUATE FROM: GRADE SCHOOL?_____HIGH SCHOOL?_____
COLLEGE?_____GRADUATE OR PROFESSIONAL SCHOOL?_____

HAS ANYONE IN YOUR FAMILY EVER HAD CANCER/_____IF SO, LIST RELATIONSHIP TO YOU AND TYPE OF CANCER?

IS YOUR MOTHER ALIVE?_____IF NOT, WHAT DID SHE DIE OF AND AT WHAT AGE _____

DOES /DID SHE HAVE ANY MEDICAL PROBLEMS?_____ LIST HERE_____

IS YOUR FATHER ALIVE?_____IF NOT, WHAT DID HE DIE OF, AND AT WHAT AGE _____

DOES/DID HE HAVE ANY MEDICAL PROBLEMS?_____LIST HERE_____

HOW MANY BROTHERS AND SISTERS DO YOU HAVE? _____ PLEASE LIST ALL SERIOUS ILLNESSES THAT ANY OF THEM HAS HAD _____

HOW MANY CHILDREN DO YOU HAVE? _____ PLEASE LIST ALL SERIOUS ILLNESSES THAT ANY OF THEM HAS HAD_____

PLEASE LIST YOUR MOST RECENT

COLONOSCOPY_____

PAP SMEAR_____

MAMMOGRAM_____

IN ORDER TO MAKE THE OFFICE RUN SMOOTHLY, YOU MAY SEE EITHER DR. CHANG, DR. HARVEY HSIANG,OR DR. Y. HENRY HSIANG, (pronounced as “SHUNG”), EVEN IF YOUR REFERRAL IS FOR A SPECIFIC DOCTOR.

FOR MORE INFORMATION VISIT US AT WWW.EMERALDCOASTCANCERCENTER.COM

PRIVATE PAY PATIENT

If you are not covered by insurance or prefer to file your own insurance and pay cash for medical services provided, please complete and sign the form below. We require a guarantor signature for all minors, full-time students or other dependents.

UNLESS *PRIOR ARRANGEMENTS ARE MADE, ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. YOU MAY PAY CASH, CHECK OR WITH THE DISCOVER CREDIT CARD. After each visit, our business office personnel will speak privately with you and calculate your payment due for that day's medical care.

*If you wish to discuss a payment plan or have questions about fees, please let the receptionist know and you may speak privately with our business manager.

I PREFER TO PAY CASH, CHECK OR CHARGE TO MY DISCOVER CARD ACCOUNT FOR ANY OFFICE CHARGES. BILLS, RECEIPTS AND INSURANCE FORMS WILL BE PROVIDED TO ME IF NECESSARY AND I WILL FILE THE INSURANCE CLAIM MYSELF. IF THIS ACCOUNT IS ASSIGNED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION AND/OR SUIT, THE PREVAILING PARTY SHALL BE ENTITLED TO REASONABLE ATTORNEY'S FEES AND COSTS OF COLLECTION. THE UNDERSIGNED GUARANTOR SECURES AND WARRANTS THE TIMELY PAYMENT OF THE OBLIGATIONS OF THE PATIENT AS SET FORTH ABOVE.

DATE_____ _____Patient

_____Print Name

_____Guarantor

_____Print Name

_____Witness

_____Print Name

GUARANTOR ADDRESS_____

GUARANTOR TELEPHONE HOME#___-___-____ WORK#___-___-____

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Destin, Fl 32550

Ming-Chen Chang, M.D.
Harvey Y. Hsiang, M.D., PHD
Y. Henry Hsiang, M.D., PHD
Jaime Braden, NP-C

REQUEST FOR RELEASE/REQUEST OF MEDICAL RECORDS

***Please print clearly!

Date: _____

To:

_____
(Previous physician/practice name)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # _____ Fax # _____

I hereby request that my medical records be released to us or by us

EMERALD COAST CANCER CENTER

1024 Mar Walt Drive
Ft. Walton Beach, Fl 32547
Phone: 850-863-3148
Fax: 850-863-3132

7720 US Hwy 98W, Suite 240
Destin, Fl 32550
Phone: 850-622-8165
Fax: 850-622-8164

Date of Birth: _____

Patient Name Printed: _____

Patient Signature: _____

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DESTIN, FL 32550

PATIENT RECORD OF DISCLOSURES

Name: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information(PHI). The individual is also provided the right to request confidential communications or that a communication is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner(check all that apply):

Home Telephone:_____
___ O.K. to leave message with detailed information
___ Leave message with call-back number only

Work Telephone:_____
___O.K. to leave message with detailed information
___Leave message with call-back number only

Written Communication
___O.K. to mail to my home address
___O.K. to mail to my work/office address
___O.K. to fax to this number _____

According to the HIPPA laws, we may also release information to the people you specify. Please list the people we may release your protected health information (PHI) to and their relationship to you:

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature **Date**

_____ _____
Print Name **Date of Birth**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to users or disclosures made pursuant to an authorization requested by the individual

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

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MING-CHEN CHANG, M.D.
HARVEY Y. HSIANG, M.D., PHD
Y. HENRY HSIANG, M.D., PHD
JAIME BRADEN, NP-C

FINANCIAL POLICY

BASIC POLICY: Payment for service is due in full at the time services are rendered in our office.
FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care.
MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
MEDICAID PATIENTS: All Medicaid patients must provide a current, valid insurance card before being seen.
NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are rendered or upon notice of insurance claim denial.

CHECK ONE:I have paid my insurance deductible for the calendar year____ __Yes __No __Don't know

MEDICARE PATIENTS: I request payment of authorized Medicare benefits be made on my behalf to Emerald Coast Cancer Center for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. The coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient's Name(Print):_____

Patient's Signatue:_____

Patient's Medicare No:_____ Date:_____
ASSIGNMENT OF INSURANCE BENEFITS – Patients with insurances, please read and sign below. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Emerald Coast Cancer Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date:_____
I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature:_____ Date:_____

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances if you are denied. Access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.

Amend: If you feel that medical information is incorrect, you may ask us to amend(not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment or healthcare operations.

Request Confidential Communications: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury and OSHA compliance.

A Paper Copy of this Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at (850)863-3148.

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 1024 Mar Walt Drive, Ft. Walton Beach, Fl, 32547. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of Notice of Privacy Practices, Office of Emerald Coast Oncology & Hematology, Assoc. (Doing business as Emerald Coast Cancer Center)

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

Office use only:
Date Acknowledgement received_____by_____

Or reason Acknowledgement was not obtained _____

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