

Emerald Coast Oncology and Hematology Assoc, PA

NEW PATIENT INFORMATION FORM

1024 Mar-Walt Drive
 Fort Walton Beach, FL 32547
 Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
 Melissa M. King, M.D. FACP
 Aaron T. Henderson, D.O.

Patient name:	Date of Birth:
Home address:	Social Security #:
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Mailing address:	Please mark preferred contact number:
(if different)	<input type="checkbox"/> Home phone:
	<input type="checkbox"/> Cell phone:
	<input type="checkbox"/> Work phone:
Email Address:	
Place of Work:	Employer Phone:
Highest grade completed: <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
Race/ Ethnicity:	
Preferred language:	

<u>Advance Directives:</u>				
Do you have a living will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Would like more information
Do you have a power of attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Would like more information
Do you have a DNR (Do Not Resuscitate)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Would like more information

<u>Insurance Information:</u>			
Primary Insurance		Employer	
Policy #		Group Number	
Policy Holder Name		Policy Holder SSN	
Policy Holder DOB			

Secondary Insurance		Employer	
Policy #		Group Number	
Policy Holder Name		Policy Holder SSN	
Policy Holder DOB			

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NEW PATIENT INFORMATION FORM

Referring Doctor/Specialty:	Phone #:
Address (if not local):	

Other Doctors:	
Physician/Specialty:	Phone #:
Address (if not local):	
Physician/Specialty:	Phone #:
Address (if not local):	
Physician/Specialty:	Phone #:
Address (if not local):	

Preferred Pharmacy:	Phone #:
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NEW PATIENT INFORMATION FORM

Social History

Tobacco use: Never smoked

Former smoker: Packs per day: _____ # years smoked: _____ Year quit: _____

Current smoker: Packs per day: _____ # years smoked: _____

Smokeless tobacco products: Type: _____ How often: _____

Alcohol use: Never

Former: Approximate date stopped: _____

Current: Drinks per day: _____ OR Drinks per month: _____

Recreational drug use: Never

Former: Types used: _____ Last used: _____

Current: Types used: _____ Last used: _____

Occupation: Never employed

Full-time List: _____

Part-time List: _____

Retired Former: _____

Disabled Former: _____

Other or N/A: _____

Any hazardous occupational exposures: None Yes, type: _____

Marital Status: Single Married Divorced Widowed Other _____

Children: Yes; how many: _____ No

Who do you live with? _____

Family History (please list any cancer or blood disorders in your family)

Mother Living Deceased age: _____ from _____ Other health problems: _____

Father Living Deceased age: _____ from _____ Other health problems: _____

Sibling Living Deceased age: _____ from _____ Other health problems: _____

Sibling Living Deceased age: _____ from _____ Other health problems: _____

Child Living Deceased age: _____ from _____ Other health problems: _____

Child Living Deceased age: _____ from _____ Other health problems: _____

Other family medical history: _____

Have you or anyone in your family ever had genetic testing? Yes No

If so, please list results: _____

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NEW PATIENT INFORMATION FORM

Healthcare maintenance

- | | | |
|--|-------------|---------------------------|
| <input type="checkbox"/> Colonoscopy | Date: _____ | Facility/physician: _____ |
| <input type="checkbox"/> Stomach scope (EGD) | Date: _____ | Facility/physician: _____ |
| <input type="checkbox"/> Mammogram (if applicable) | Date: _____ | Facility: _____ |
| <input type="checkbox"/> Bone density (DEXA scan) | Date: _____ | Facility: _____ |
| <input type="checkbox"/> PSA (if applicable) | Date: _____ | Physician: _____ |

Vaccinations

- | | | | |
|---|-------------|-----------------------------------|-------------|
| <input type="checkbox"/> Influenza (flu shot) | Date: _____ | <input type="checkbox"/> COVID-19 | Date: _____ |
| <input type="checkbox"/> Shingles | Date: _____ | <input type="checkbox"/> Other | Date: _____ |
| <input type="checkbox"/> Pneumovax | Date: _____ | | |

Miscellaneous

- Have you ever had a blood transfusion? Yes No Not sure
- Have you ever had or been treated for tuberculosis? Yes No Not sure
- Do you drink coffee, tea, or caffeinated beverages? Yes No _____ cups per day
- Have you ever had psychiatric treatment or hospitalization? Yes No
- Have you traveled outside the United States? Yes No
- List locations: _____

Females Only

- | | |
|---|---|
| Age at first menstrual period: _____ | Age at menopause: _____ |
| # of pregnancies: _____ | # of live births: _____ |
| Age at first full term pregnancy: _____ | Breastfed: <input type="checkbox"/> yes <input type="checkbox"/> no |
- Hysterectomy: yes no
- Ovaries removed: yes no
- | | | |
|---|-----------------------|---------------------|
| <input type="checkbox"/> Birth control: <input type="checkbox"/> yes <input type="checkbox"/> no Type: _____ | # of years use: _____ | Year stopped: _____ |
| <input type="checkbox"/> Hormones: <input type="checkbox"/> yes <input type="checkbox"/> no | # of years use: _____ | Year stopped: _____ |

Emerald Coast Oncology and Hematology Assoc, PA

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

1024 Mar-Walt Drive
 Fort Walton Beach, FL 32547
 Phone (850) 863-3148 Fax (850) 863-3132

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer.)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself --or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(Office use only) Total score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Emerald Coast Oncology and Hematology Assoc, PA

APPOINTMENT CANCELLATION/ NO-SHOW POLICY

**1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132**

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Thank you for trusting your medical care to Emerald Coast Cancer Center. When you schedule an appointment with us, we set aside time to provide you with the highest quality care. Providing quality treatment for all our patients in a timely manner is a major priority for our practice, and last-minute cancellations can cause hardships for many individuals. Please see our Appointment Cancellation/ No-Show Policy below:

- Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment.
- As a courtesy, we send automated appointment reminders by text/ phone call before appointments. If you do not receive a reminder call or message, this Policy will still remain in effect. Please ensure we have your correct contact information on file.
- Effective 5/1/2023, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show.
- No Show patients will be charged a \$25 fee for the first occurrence, and \$50 for each subsequent occurrence. This fee will be charged to the patient, is not covered by insurance, and will be charged to a credit card on file at the office. If a credit card is not on file, the fee is due at the time of the patient's next office visit.
- If you have an emergency please let us know. Fees will be waived on a case-by-case basis.
- Patients who consistently miss an appointment or cancel at the last minute may be disenrolled from the clinic, or may be required to pay a reservation fee before scheduling future appointments.
- Patients who arrive fifteen (15) minutes late to a scheduled appointment may not receive all scheduled treatment and / or may be asked to reschedule the appointment.

I have read and agree to the above policy.

Patient Name (print): _____

Patient Signature: _____

Date: _____

Emerald Coast Oncology and Hematology Assoc, PA
REQUEST FOR RELEASE/ REQUEST FOR MEDICAL RECORDS

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

PLEASE COMPLETE ONLY THE BOTTOM PORTION OF THIS PAGE.

FOR OFFICE USE ONLY:

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
Fort Walton Beach, FL 32547
Phone: 850-863-3148
Fax: 850-863-3132 Alt Fax: 850-862-8668

PLEASE COMPLETE AND SIGN:

Patient Name (print): _____

Date of Birth: _____

Patient Signature: _____

Emerald Coast Oncology and Hematology Assoc, PA

HIPAA CONSENT

**1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132**

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Patient Name: _____

In general, the HIPAA 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 of PHI is made by alternative means, such as by sending correspondence to the individual's office instead of their home.

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

- | | |
|--|---|
| <input type="checkbox"/> Home/ Cell #: _____ | <input type="checkbox"/> Do not leave a message at this number |
| | <input type="checkbox"/> Ok to leave a message with details |
| | <input type="checkbox"/> Ok to leave message with call-back number only |
| <input type="checkbox"/> Work Telephone: _____ | <input type="checkbox"/> Do not leave a message at this number |
| | <input type="checkbox"/> Ok to leave a message with details |
| | <input type="checkbox"/> Ok to leave message with call-back number only |
| <input type="checkbox"/> Fax (if available): _____ | <input type="checkbox"/> Ok to send fax with details to this number |

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

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 uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Signature: _____ Date: _____

Emerald Coast Oncology and Hematology Assoc, PA
INSURANCE PATIENTS – LIFETIME AUTHORIZATION &
AUTHORIZATION TO RELEASE INFORMATION

e1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

If you are covered by insurance and want us to file claims on your behalf, please sign the following form.

I. Release of Information - I hereby authorize Y. Henry Hsiang, MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their authorized employees to release any medical information (including psychiatric, alcohol, or drug-related records) necessary for processing my insurance claims.

II. Physician Insurance Assignment - I hereby request, authorize, and direct Y. Henry Hsiang MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their authorized employees to file insurance claims on my behalf to all applicable third payers. I hereby assign all benefits due directly to Y. Henry Hsiang, MD, PhD, Melissa M. King, MD, or Aaron T. Henderson, DO. In the event that my policy prohibits payment to be made directly to the doctor, I direct my insurance company to send all checks to me in care of Emerald Coast Cancer Center at the above address.

III. Medicare/Medicaid - I authorize Y. Henry Hsiang MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their employees to bill Medicare and/or Florida Medicaid for any benefits that may be due under these programs. I certify that the info given to me pertaining to Medicare/Medicaid is correct. I hereby assign all benefits due directly to Y. Henry Hsiang, MD, PhD, Melissa M. King, MD, or Aaron T. Henderson, DO any benefits that are due under these programs. In the event that I am deemed no longer eligible for coverage under these programs, I acknowledge my responsibility for any unpaid claims.

IV. I permit a copy of this authorization and assignment to be used in place of the original which is on file at the physician's office. *This release will remain in effect until revoked by me in writing.*

I understand that you file insurance as a courtesy and convenience to me. I realize that I am responsible for any copayments, deductibles, non-covered services, and any claims not covered by my insurance or third party payers within 30 days from the date filed. All payments are required on a 30 day cycle, unless prior arrangements have been made and documentation signed by both myself and one of the doctor's representatives.

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 obligation of the patient as set forth above.

Patient Name (print): _____ Signature: _____ Date: _____

Policyholder/ Guarantor: _____

Guarantor Address: _____

Guarantor Home Phone #: _____ Work Phone #: _____

Emerald Coast Oncology and Hematology Assoc, PA
PRIVATE PAY PATIENTS

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

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, **payment in full is expected at the time of service**. 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.

By signing below, I acknowledge the above policy and agree to the following:

- I prefer to pay cash, check, or credit card for any office charges. Bills and receipts will be provided to me upon request 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 Name (print): _____

Patient Signature: _____

Guarantor Name (print): _____

Guarantor Signature: _____

Witness Name (print): _____

Witness Signature: _____

Guarantor Address: _____

Guarantor Home Phone #: _____

Guarantor Work Phone #: _____

Emerald Coast Oncology and Hematology Assoc, PA
FINANCIAL QUESTIONNAIRE FOR DRUG REPLACEMENT &
COPAY ASSISTANCE

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Information is being requested for the sole purpose of registering our patients in patient access programs in order to improve our services offered to you. These programs offer copayment / out of pocket assistance to those that qualify, and many programs will replace the medication free of charge if we receive a denial from your insurance.

Please fill out the following questions below and if possible please bring your most current tax return or other financial information (one month of recent paystubs or SSI Award Letter) to your next visit. All information will be kept confidential.

Please let us know if you do not want to share this information.

Patient Name (print): _____ Date of Birth: _____

How many in household? _____

Total income claimed on most recent tax return (if income has changed since that time, please provide most recent income amount): _____

_____ Please initial if you choose not to share this information, and decline patient assistance/ drug replacement at this time.

Patient Signature: _____ Date: _____

****ALL INFORMATION PROVIDED WILL BE KEPT COMPLETELY PRIVATE AND CONFIDENTIAL****

FORM WILL NEED TO BE COMPLETED ANNUALLY.