OKLAHOMA
CANCER SPECIALISTS
AND RESEARCH INSTITUTE

WHAT TO EXPECT AT YOUR FIRST VISIT

Please read through this information in order to make you feel more prepared for your initial visit.

- **Complete and bring with you all paperwork in your packet.** You will receive an email or text message with a link to complete your paperwork online prior to your appointment date. You will need to complete the Health History form provided in the packet. It is not available to complete online.

- Your picture will be taken.

- **We will need to copy all insurance cards.**

- All co-pays will be due at time of service. We accept cash, check, money orders, Visa, Master Card, American Express and Discover. **We will need to copy your driver's license or ID card.**

- You will meet with an OCSRI representative to review and sign your paperwork.

- **A list of your current medications will be required.**

- **All visitors should be 12 or older to enter any part of the facility.**

- Patients are allowed up to two visitors to accompany them to their visit (including in Exam rooms). Exceptions to this rule are as follows:

    - Only one visitor per patient will be permitted within the Treatment/Infusion room.

    - No visitors should enter Lab, Port Draw, or Radiation/Radiology treatment areas.

IT IS IMPORTANT ALL PAPERWORK (online or by hand) IS COMPLETE AT TIME OF APPOINTMENT. IF NOT COMPLETE, YOUR APPOINTMENT COULD BE DELAYED.

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE OR OBTAIN INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Medical Record #:_____

Request Made: ☐ In Person ☐ Written

Type of Request: ☐ Release ☐ Obtain

Patient Name	Phone No.	Date of Birth	Last 4 digits Social Security No.

By signing below, I hereby authorize Oklahoma Cancer Specialists and Research Institute and its duly authorized agents and employees to RELEASE or OBTAIN to/from the person or organization listed below my individually identifiable health information for the use and disclosure described below. I do not authorize further release to any third party.

PERSON OR ORGANIZATION INFORMATION IS TO BE RELEASED TO OR OBTAINED FROM AND PURPOSE OF RELEASE

Person/Organization to release or obtain from my information (include address)

Name of Person or Organization

Street

City | State | Zip

Purpose of release/obtain:

☐ Filing insurance
☐ Continued treatment
☐ Request of patient or their legal representative
☐ Other (specify): _____

INFORMATION TO BE USED OR DISCLOSED – *Check all that apply*

☐ Surgical Reports
☐ Radiology Images
☐ Laboratory Reports
☐ Radiology Reports
☐ Pathology Reports
☐ History and Physical
☐ Operative Report
☐ Genetic Testing Results
☐ Consultation Reports
☐ Radiation Reports
☐ Progress Notes
☐ Treatment Plan(s)
☐ Demographics (providers only)
☐ Biopsy Reports
☐ View Electronics Records
☐ Entire Chart (ALL ITEMS LISTED)
☐ Other

TREATMENT DATES REQUESTED – *Check one*

☐ All dates of service ***OR*** ☐ Treatment dates between _____ and _____

REQUEST TO RECEIVE INFORMATION ELECTRONICALLY

I will receive the information via a CD, unless otherwise specifically requested in paper.

☐ *Must have in paper format (I understand paper will cost me extra)*

I UNDERSTAND:

- This authorization will expire 12 months from date signed
- **The information authorized for use or disclosure may include information which may indicate the presence of communicable or non-communicable disease.**
- I may cancel this authorization at any time. This cancellation will not apply to information already released/obtained based on this authorization.
- This authorization automatically ends when the information is released or obtained
- The person or organization receiving information based on this authorization could re-release the information to others and federal law would no longer protect it. I release the hospital and its staff, employees, officers and directors from any responsibility from such re-release.
- Oklahoma Cancer Specialists and Research Institute will not base treatment, payment, enrollment in a health plan or eligibility for benefits upon getting this authorization.

With this knowledge, I voluntarily give my consent to the use and disclosure of individually identifiable health information including information concerning my identity and release Oklahoma Cancer Specialists and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained herein.

Signature of Patient/Personal Representative	Date	Time	Patient/Personal Representative ID verified by: ☐ Picture ID ☐ Other (specify): _____
Authority of Personal Representative to act on behalf of Patient			
Reason Patient Unable to Sign			
Signature of Witness	Date	Time	

TRANSLATION: *This certifies that this Authorization was read to the patient or their personal representative in his/her native language; all representations that appear in the Authorization were understood and authorized by the patient or their personal representative.*

Interpreter's Signature	Date	Time

CONFIDENTIAL INFORMATION

Medical Record Pricing

Pricing listed below is in accordance with Oklahoma Statue 76-19(A)(2):

Patients-
Paper: $0.50 per page
Electronic: $10.00 base fee and $0.30 per page and delivery fee

Attorney or Insurance via a subpoena-
Paper: $10.00 base fee and $0.50 per page and postage/delivery
Electronic: $10.00 base fee and $0.30 per page and delivery fee

Maximum fee-$200.00

Radiology (x-ray or other images)-$5.00

Social Security-$18.00

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT AGREEMENT

DISCLOSURE OF INFORMATION

I understand that my medical and billing records are maintained by Oklahoma Cancer Specialists and Research Institute (OCSRI) and are accessible to personnel. OCSRI personnel may use and disclose medical information for treatment, payment or operations to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. OCSRI and it's personnel are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the services rendered. Oklahoma law requires OCSRI to advise you that the **information authorized for use or disclosure may include information which may indicate the presences of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse.** By signing this agreement, you are consenting to such disclosure. _____
initial

ASSIGNMENT OF INSURANCE BENEFITS

My rights to payment for all drugs, procedures, tests, equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to OCSRI. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurances and any other health plans. I acknowledge this document as a legally binding assignment/agreement to collect my benefits as payment representative; I will endorse such payments to OCSRI. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit care at the time of service. _____
initial

FINANCIAL RESPONSIBIILITY

I acknowledge I have received, understand and agree to the terms listed in the OCSRI's Financial Policy. _____
initial

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have received, read and understand my Patient Rights and Responsibilities. _____
initial

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient, or Legal Representative for the patient, and I accept the terms of this patient Agreement. A photocopy of this document has the same effect as an original.

Signature: _____ **Relationship to Patient:** _____
(if applicable)

Printed Name: _____ **Account Number:** _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by OCSRI is in our **NOTICE OF PRIVACY PRACTICES**, which you have received.

I have received a copy of the **Notice of Privacy Practices**.

Signature: _____ **Relationship to Patient:** _____ **Date:** _____
(if applicable)

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

FINANCIAL POLICY

Thank you for choosing Oklahoma Cancer Specialists and Research Institute (OCSRI) for your medical care. We look forward to serving your needs. We want you to be an informed participant in your medical care. Therefore, we have summarized our financial policy for you in order for you to be aware of our expectations regarding your financial obligations to OCSRI.

If OCSRI has a contract with your insurance company, we will be happy to bill your insurance company for you after verification of your coverage benefits. Your coverage benefits include eligibility, service coverage, deductibles, co-insurance percentage, and copay amounts. **All patients are required to bring their insurance cards with the policy ID number and insurance company phone number. If you do not have your insurance card and/or we cannot confirm coverage, you will be required to pay in full at time of service.** Patients are expected to pay in full any applicable co-pays, deductible and/or co-insurance expense at the time services are rendered in our office. If we are unable to determine your financial responsibility at the time of service, payment is due **IN FULL** as balances are incurred. Based on the contract in place with your insurance company, we are required to collect your co-pays, deductible, and co-insurance. These balances cannot be waived.

OCSRI will make every reasonable effort to collect payments due from your insurance company. However, you are ultimately responsible for all services rendered, as well as assuring timely payment from your insurance company. We recommend you follow-up with your insurance company on any outstanding balance you may have with OCSRI. You will be liable for any service considered not medically necessary or cosmetic by your insurance company as well as all non-covered or reimbursed services. We will inform you if any of your services have the potential to fall within these category. In the event of non-payment, you will assume the cost of interest, collection and legal action (if required).

OCSRI will review your benefits at the time of services rendered to best gauge your personal liability. All quotes given by OCSRI are estimates based on the plan information available to us at the time of review. These estimates are not a guarantee of maximum liability and we encourage you to reach out to your insurance plans to obtain a clear understanding of how your co-pays, deductibles, and out of pocket expenses may apply to the services you are receiving.

OCSRI accepts Medicare assignment. If you do not have secondary insurance coverage, we are required by law to collect the 20% co-insurance of the Medicare allowable. We are also required to collect the annual Medicare deductible, if you have not met your deductible prior to your appointment. Medicare only pays for services they deem medically necessary. We will inform you if any of your services have the potential to fall outside of this category, as you are responsible for payment of all non-covered services at the time of service.

Some of your laboratory tests, biopsies, cultures, radiological services obtained by the physician during your appointment, may be sent to an outside provider and will not be part of your office services at OCSRI. You will receive a separate bill from the outside provider. OCSRI is not obligated to pay for these service in anyway, covered or non-covered by your insurance company.

OCSRI is happy to offer the following payment options:

- Cash, checks, Visa, MasterCard, American Express, and Discover. We cannot accept personal third party checks or post-dated checks
- Payment plans at various interest rates with approved application

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Your right to payment for all drugs, procedures, test, equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to OCSRI. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurances and any other health plans. You acknowledge this document as a legally binding assignment/agreement to collect my benefits as payment representative; you will endorse such payments to OCSRI.

I authorize my insurance carrier(s) to release information regarding my coverage to Oklahoma Cancer Specialists and Research Institute

*If I request to apply for a payment plan, I understand Oklahoma Cancer Specialists and Research Institute will inquire into my credit history through a credit reporting agency. I understand that this information will solely be used for the purpose intended and will NOT be released to any outside agency.

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT HISTORY AND PHYSICAL

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date: _____ Name: _____

Birth date: _____ Age: _____ Race: _____

REFERRING PHYSICIAN

Name: _____ City: _____ Phone number: _____

Why are we seeing you today? _____

List your recent physicians

PHYSICIAN	SPECIALTY

List recent radiology from the past 6 months (i.e., chest X-ray, mammogram, CT scan, PET scan, MRI)

	DATE	TYPE OF RADIOLOGY	ORDERING PHYSICIAN	HOSPITAL/FACILITY
1.				
2.				
3.				

List lab work (past 6 months)

	DATE	TYPE	ORDERING PHYSICIAN	HOSPITAL/FACILITY
1.				
2.				
3.				

Eff 04012020

SURGERIES OR HOSPITALIZATIONS

	DATE	PHYSICIAN	REASON	HOSPITAL/FACILITY
1.				
2.				
3.				

List any biopsies or tissue removed

	DATE	PHYSICIAN	REASON	HOSPITAL/FACILITY
1.				
2.				
3.				

PERSONAL HEALTH HISTORY

(please check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Palpitations/Flutter
- ☐ Pacemaker
- ☐ Respiratory Disease
- ☐ Chronic Fever
- ☐ Hay Fever
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Positive TB Test
- ☐ Emphysema/COPD
- ☐ Seizures/Strokes
- ☐ Digestive Disease
- ☐ Colitis
- ☐ Stomach Ulcers
- ☐ Hiatal Hernia/Reflux
- ☐ Liver Disease
- ☐ Genital/Urinary
- ☐ Kidney Disease
- ☐ Difficulty Voiding
- ☐ Menstrual Difficulties
- ☐ Sexual Dysfunction
- ☐ Arthritis
- ☐ Goiter/Thyroid Disease
- ☐ Migraine Headaches
- ☐ Mental Illness
- ☐ Depression
- ☐ Nervous Breakdown
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clots in Legs/Lungs
- ☐ Other _____

If you checked any of the above, please explain below

List any radiation treatments you have had

DATE PHYSICIAN TREATMENT FACILITY

1. _____

2. _____

3. _____

List ANY blood transfusions you have had

DATE HOSPITAL ANY REACTION?

1. _____

2. _____

3. _____

Preferred pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

24-Hour pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICATIONS

List all medications you are currently taking (including over the counter and supplements)

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

ALLERGIES

Are you allergic to any medications, foods, IV contrast, X-ray dye or latex?

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Are you diabetic? ☐ No ☐ Yes Do you have any metal implants? ☐ No ☐ Yes

Are you claustrophobic? ☐ No ☐ Yes

IMMUNIZATIONS

Check all that apply and date received if known

☐ Hepatitis B _____ ☐ Influenza (annually)_____

☐ Pneumovax 23 Valent* _____ ☐ PrevnarPneum. 13 Valent* _____

*Most patients will require both pneumonia vaccines (23 & 13 Valent)

☐ HPV #1 _____ ☐ Shingles _____

☐ HPV #2_____

☐ HPV #3_____

ADVANCE CARE PLANNING

Please check if you currently have any of the following in place and please bring a copy to the office :

LIVING WILL

☐ Yes, I have provided a copy

☐ Yes, I will bring a copy at my next visit

☐ No, but I would like assistance in completing one

☐ No, I am not interested at this time

DNR (DO NOT RESUSCITATE)

☐ Yes, I have provided a copy

☐ Yes, I will bring a copy at my next visit

☐ No, but I would like assistance in completing one

☐ No, I am not interested at this time

POWER OF ATTORNEY

☐ No

☐ Yes, I have provided a copy

☐ Yes, I will bring a copy at my next visit

SOCIAL HISTORY

Smoking

- ☐ Never smoked
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Heavy tobacco smoker (>10/day)
- ☐ Former smoker
  Date Stopped _____
- ☐ Light tobacco smoker (<10/day)
- ☐ Pipe smoker
- ☐ Chews tobacco
- ☐ Snuff user
- ☐ User of moist powdered tobacco
- ☐ Vaping

Years of tobacco use: _____ Packs per day: _____

Alcohol Use

☐ Never ☐ Current Use ☐ Former Use Stopped alcohol use (year): _____

Drinks per day: _____ Drinks per week:_____ Drinks per month: _____ Drinks per year:_____

Recreational Substance use: ☐ Yes ☐ No Type:_____

Medical Marijuana use: ☐ Yes ☐ No If yes, do you have a license? ☐ Yes ☐ No

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Separated

Are you currently working? If yes, where? _____

If you are not working is it secondary to: ☐ Retirement ☐ Disability ☐ Leave of Absence ☐ Sick Leave ☐ Other

Do you live alone? If not, who lives at home with you? _____

Are you able to care for yourself? ☐ Yes ☐ No

Are you currently living in a skilled nursing facility or a nursing home? ☐ Yes ☐ No

Are you the primary caregiver for someone unable to care for themselves? (child, spouse, aging parent, etc.)
☐ Yes ☐ No

What type of support system do you have in town? (family, friends, church, neighbors, etc.)

If medically indicated, would you receive a blood transfusion? ☐ Yes ☐ No

Check ONLY ONE BOX to describe your activity level:

- ☐ 0—Normal with no limitations
- ☐ 1—Not my normal self but able to be up and about with fairly normal activities
- ☐ 2—Not feeling up to most things but in bed or chair less than half the day
- ☐ 3—Able to do little activity and spend most of the day in bed or chair
- ☐ 4—Pretty much bedridden and rarely out of bed

FAMILY HEALTH HISTORY

Please include the following: Hypertension, Heart Attack, Congestive Heart Failure, Stroke, Emphysema, COPD, Tuberculosis, HIV, Hepatitis, Liver Disease, Anemia, Bleeding, Blood Clots in the legs or lungs, Kidney Disease, Thyroid Disease, Diabetes, Cancer (Breast, Ovarian, Colon, Lung Skin, other), Leukemia, other

PARENTS

Name	Age	Health problems	If deceased, age & cause of death
Father:			
Mother:			

SIBLINGS

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

SPOUSE

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			

CHILDREN

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

REVIEW OF SYSTEMS

(please check all that currently apply)

GENERAL

- ☐ Weight loss or gain #lbs_____
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Fever—temp max_____ when_____
- ☐ Chills

EYES

- ☐ Blurred vision
- ☐ Difficulty seeing
- ☐ Dry eyes

EARS/NOSE/MOUTH THROAT

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Bleeding gums
- ☐ Nasal drainage
- ☐ Nose bleeds
- ☐ Smell changes
- ☐ Sores in mouth
- ☐ Taste changes
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Sore throat

CARDIAC

- ☐ Chest pains
- ☐ Heart palpitations
- ☐ Light headaches
- ☐ Swelling in legs
- ☐ Episodes of passing out

Date of last EKG _____

RESPIRATORY

- ☐ Cough
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ Pain with breathing
- ☐ Shortness of breath

Date/Result of last TB test _____

Date/Result of chest x-ray _____

BREAST

- ☐ Masses/dimpling
- ☐ Nipple discharge
- ☐ Nipple inverted
- ☐ Asymmetry
- ☐ Redness/erythema
- ☐ Scar

BREAST (CONT.)

Date/result of last mammogram _____

Lump/masses_____

Date/location of facility_____

_____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Constipation—last BM _____
- ☐ Diarrhea—# stools in 24 hrs _____
- ☐ Abdominal pain
- ☐ Rectal bleeding
- ☐ Bloating
- ☐ Difficulty swallowing solids or liquids
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Bowel incontinence

Date of rectal exam _____

Date of last colon screening _____

Date of fecal occult blood test _____

Date of sigmoidoscopy _____

Date of colonoscopy _____

MUSCULO-SKELETAL

- ☐ Muscle stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Back pain
- ☐ Bone pain

SKIN

- ☐ Skin rash
- ☐ Skin lesions
- ☐ Acne
- ☐ Dryness
- ☐ Changes in moles
- ☐ Infections
- ☐ Nail changes

NEUROLOGICAL

- ☐ Headaches
- ☐ Seizures
- ☐ Double vision
- ☐ Dizziness
- ☐ Loss of balance

NEUROLOGICAL (CONT.)

- ☐ Weakness of limbs
- ☐ Numbness or tingling:
  Location_____
- ☐ Memory loss
- ☐ Confusion

HEMATOLOGIC/LYMPHATIC/ IMMUNOLOGIC

- ☐ Bruising
- ☐ Bleeding
- ☐ Swollen lymph nodes
- ☐ Clotting abnormalities

MEN ONLY

- ☐ Lesions
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Testicular masses or pain
- ☐ Penile discharge
- ☐ Impotence
- ☐ Are both your testicles descended?
- ☐ Are you circumcised?

Date/result of last PSA _____

WOMEN ONLY

- ☐ Lesions
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Vaginal discharge
- ☐ Itching
- ☐ Abnormal bleeding
- ☐ Painful periods

Age at first menstruation?_____

Age at menopause? _____

Number of live births?_____

Number of miscarriages? _____

- ☐ Have you had a hysterectomy?
- ☐ Have you had your ovaries removed?
- ☐ Have you used birth control pills?
- ☐ Have you used estrogen?
- ☐ History of abnormal PAP smear

Date of last pelvic & PAP smear_____

Physician: _____

Result: _____

MAYO PAIN SCALE

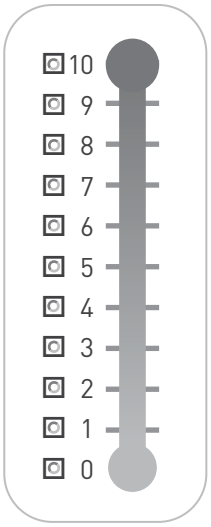
☐ 0–1: No pain ☐ 2–3: Mild pain ☐ 4–5: Discomforting to moderate pain ☐ 6–7: Distressing, severe pain

☐ 8–9: Intense, very severe pain ☐ 10: Unbearable pain Location: _____

HELP FOR DISTRESS

The Distress Thermometer helps your treatment team know if you need supportive services. You may be referred to supportive services at your cancer center or in your community. Supportive services can include help from support groups, chaplains, social workers, counselors and many other experts.

Please check the number 0–10 that best describes how much distress you have been experiencing in the past week, including today



Please indicate if any of the following has been a problem for you in the past week including today. Be sure to check "yes" or "no" for each.

Yes	No	Emotional Problems
◯	◯	Depression
◯	◯	Anxiety
◯	◯	Difficulty coping
◯	◯	Sadness
◯	◯	Restlessness
◯	◯	Difficulty sleeping
◯	◯	Sex drive changes
◯	◯	Spiritual/religious concerns

Yes	No	Family Problems
◯	◯	Dealing with children
◯	◯	Dealing with partner
◯	◯	Ability to have children
◯	◯	Family health issues

Yes	No	Practical Problems
◯	◯	Child care
◯	◯	Housing
◯	◯	Insurance/financial
◯	◯	Transportation
◯	◯	Work/school
◯	◯	Treatment decisions

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PH: 918-505-3200
www.ocsri.org

NEW PATIENT REFERRAL

Department of Gynecologic Oncology

CHECK IF APPLICABLE

☐ DARON STREET, MD ☐ MICHAEL A. GOLD, MD ☐ A. DWAYNE JENKINS, MD ☐ ERIC THOMAS, MD ☐ KATHERINE MOXLEY, MD

Sara White, APRN, CNS, AOCNS • Diane Reed, MSL, BSN, RN - MANAGER • Andrea Carpenter, APRN CNP, FNP - BC

PLEASE PRINT CLEARLY

Referral Form: Fax to 918-592-3809

Referring provider: _____

Office contact person: _____ Phone # or ext: _____

Refer to Department of Gynecologic Oncology

Patients will be scheduled with the first available surgeon to allow access to care unless previously discussed with a specific provider.

Patient's name: _____ DOB: _____

Reason for referral: (Please be specific; we schedule based on clinical triage information.)

Other: _____

CHECK ALL THAT APPLY

- ☐ Abnormal Pap
- ☐ Abnormal Vaginal Bleeding
- ☐ Cervical/Vaginal Dysplasia
- ☐ Vulvar Cancer
- ☐ Cervical Cancer
- ☐ Gest. Trophoplastic Neoplasm
- ☐ Endometrial Hyperplasia
- ☐ Endometrial Cancer
- ☐ Uterine Fibroids or Tumors
- ☐ Ovarian Cancer (Confirmed/Suspected)
- ☐ Large Pelvic Mass
- ☐ Complex Cysts
- ☐ Elevated CA-125
- ☐ Genetic Predisposition to GYN Cancer (BRCA+)

Patient's primary insurance: _____

ID #: _____ Group #: _____

Phone #: _____ Medicaid referral initiated? ☐ Yes ☐ No

Referrals will NOT be processed without the following information. Please mark all that apply or N/A if records do not exists. If test results (lab, imaging, etc.) are pending please document.

____ Patient demographics, including all phone numbers
____ Legible copy of insurance card
____ Pathology confirming above diagnosis
____ Pap smear results (any available including normal)
____ Any imaging results: ☐ CT scan, ☐ Ultrasound, ☐ PET/CT, ☐ MRI, etc. (check all that apply)
Patient should arrive to appointment with a CD copy of imaging for review
____ Progress/procedure notes from referring provider
____ All previous operative reports available to the patient should be obtained
____ Other records may be obtained at Dr. _____ office or _____ hospital

12697 East 51st Street South • Tulsa, OK 74146

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS OR FRIENDS

Many of our patients allow family members and friends to call and request information related to appointments, medical, prescriptions or billing. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have this type of information released, including prescription pick-up, this form must be signed. Signing this form will only give consent to release this information to the family members or friends indicated below. This authorization shall be in force and effective for the duration of 12 months from date of signature, at which time this authorization will expire.

You have the right to revoke this consent in writing.

I authorize/allow Oklahoma Cancer Specialists and Research Institute to release my information to the following individual(s):

_____ Relation to Patient _____ Phone _____

_____ Relation to Patient _____ Phone _____

_____ Relation to Patient _____ Phone _____

II. ACKNOWLEDGEMENTS AND SIGNATURES

A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Oklahoma Cancer Specialists and Research Institute.

D. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.

E. Right to Revoke – I understand I may change this authorization at any time by writing to Oklahoma Cancer Specialists and Research Institute. I understand I cannot restrict information that may have already been shared based on this authorization.

F. This document must be signed by the patient or the patient's legal representative.

Patient or Legal Representative

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____
(if applicable)

Account Number: _____

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT RIGHTS

As a patient, I have the right to:

- Full information about my rights and responsibilities as a patient in a physician's office.
- Receive in terms I can understand:
  - An explanation of my medical condition.
  - The benefits and risks of the treatments my doctor recommends.
  - Alternatives to that treatment.
  - An understanding of the consequences if I choose not to undergo recommended treatment.
- An explanation of all rules, regulations and services provided by the doctor's office, including the days and hours of service and how to reach a physician after regular office hours.
- Choose my own physician and be informed of the names, areas of responsibility and experience of the staff.
- Participate in developing my Plan of Care including an Advance Directive.
- Participate, or refuse to participate, in any research study or aspect of care including investigational studies and freely withdraw previously given consent for further treatment.
- Full financial explanation and payment schedules prior to beginning any treatment.
- Receive expert, professional care without discrimination regardless of race, creed, color, religion, national origin, handicap, sexual preference, sex or age.
- Be treated with courtesy, dignity and respect of my personal privacy by all practice employees.
- Complain or file grievance with the Practice Administrator without fear of retaliation or discrimination.
- Confidential treatment of my condition, medical record and financial information.
- Obtain copies of my personal records upon my request.

PATIENT RESPONSIBILITIES

As a patient, I have the responsibility to:

- Provide accurate and complete information related to my physical condition, hospitalizations, medications, allergies, medical history and related items.
- Provide new or changed information related to my health insurance to the practice business office and be prepared to meet my co-pay requirements during office visits.
- Treat physicians, advanced practitioners, staff and other patients with courtesy, dignity and respect regardless of race, creed, color, religion, national origin, handicap, sexual preference, gender or age. Inappropriate, discriminatory or derogatory comments will not be permitted.
- Refrain from aggressive or threatening behavior -verbal or physical. Disruptive acts or hostile behavior toward staff, licensed practitioners, or other patients or visitors will not be tolerated.
- Contact the office in advance when unable to keep a scheduled appointment.
- Request more detailed explanations for any aspect of service I do not understand.
- Inform my physician or nurse of any changes in my condition or any new problems or concerns.
- Inform my physician or nurse about prescription refill needs before my supply is gone.
- Communicate any change in my address or telephone number to the practice business office.
- Participate and cooperate in my Plan Of Care, Advance Directive and Living Will.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003
Revised: February 23, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Federal Government's Health Insurance Portability and Accountability Act (HIPAA) require covered health care providers to issue a Privacy Notice to their patients. This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected.

Oklahoma Cancer Specialists and Research Institute (OCSRI) understands that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately. We will abide by the terms of this Notice.

HOW THE COMPANY MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We use an electronic medical record. This is a computer system that allows OCSRI providers and other providers that are not related to us to read and add health information about you.

The following categories describe some of the ways that OCSRI may use and disclose your health information.

Treatment: We may use your health information to provide you with medical treatment or services. *Example:* Your health information will be disclosed to the oncology nurses who participate in your care. We may also disclose your health information to other health care providers involved in your care to ensure those parties have all the information necessary to help diagnose and treat you.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining financial and non-financial support for your care.

Payment: We may use your health information for payment activities, including but not limited to, determining plan coverage, billing/collection, and assisting another health care provider with payment activities. *Example*: Your health information may be released to an insurance company to obtain pre-approval of services or payment for services.

Health Care Operations: We may use and disclose your health information to support our health care operations. *Example:* Your health information may be used for quality assessment/improvement activities or conduct internal audits to verify proper billing procedures.

Research: We may use and disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Business Associates: We may disclose your health information to other individuals or companies that provide a service to or on OCSRI's behalf. Your health information will be released only if we have received satisfactory assurance through a written agreement that these entities will properly safeguard your information. *Example:* Your health information may be released to business associates involved in billing or transcription services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be of interest to you. *Example:* We may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information to a family member, friend, or legal guardian who is involved in your care or who helps pay for your care unless you asked us not to. If you are unable to agree or object to these disclosures, our health care professionals will use their best judgment in communicating with your family and others.

YOUR HEALTH INFORMATION RIGHTS

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, and administrative action or proceeding. You must make your request in writing by filling out the appropriate form provided by us. We may charge you for health records in a paper or digital format and cost of mailing in accordance with state and/or federal laws.

Right to Request Changes: You have the right to identify and request changes or additions to your health information when you believe information is incorrect or incomplete. It is up to your provider whether or not the requested change or addition will be made to the health record. However, your written request for changes or additions will remain with your health record.

Right to a Copy of This Notice: You have the right to receive a copy of this Notice electronically or obtain a paper copy of the Notice from us upon request. The Notice is posted and available at each of OCSRI's location(s) and on our website.

Right to Accounting of Disclosures: You have the right to request a free list of certain disclosures every 12 months. We are not required to list all disclosures, such as those authorized or made for treatment, payment, or operations. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. If you request more than one accounting in a 12 month period, we may charge you for the cost of the list. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to Request Confidential Contacts: You have the right to request that OCSRI contact you about medical issues in a certain way or place, such as by mail. You must specify how or where you want to be contacted. We will attempt to accommodate all reasonable requests.

Right to Request Restrictions: You have a right to request a limit on the medical information released to others involved in your care or the payment of your care. Your provider has the right to deny the request, but must provide you with a reason if it cannot be met. You may request to restrict disclosure of protected health information to a health plan if the healthcare item or service is paid out of pocket in full at time of delivery.

Right to Be Informed About Privacy and Security Breaches: You have the right to expect that we will hold staff responsible for any improper access, use, or release of your health information. You have the right to expect that if your protected health information has been compromised, we will investigate the breach as required by law and you will be notified and assisted accordingly.

USES AND DISCLOSURES OF HEALTH INFORMATION REQUIRED OR PERMITTED BY LAW

The following categories describe some of the ways that OCSRI may be allowed or required to use and disclose your health information without your consent or agreement.

Law Enforcement: We may disclose your protected health information if required by federal, state, or local law, such as when required by a court order, cases involving felony, or to the extent an individual is in the custody of law enforcement.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Public Health and Safety/Serious Threat: We may use and disclose your health information to public health or legal authorities charged with preventing or controlling disease, abuse or neglect, disaster relief assistance, and averting a serious threat to the health and safety of a person or the public.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner or funeral director as necessary for them to carry out their duties.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Workers' Compensation: We may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Specialized Government Functions: We may disclose your health information to national security agencies for the protection of persons or to conduct special investigations. If you are in the armed forces or reserves, your health information may be disclosed to military authorities.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the health information necessary for your health and the health and safety of other individuals.

OTHER INFORMATION TO KNOW

Oklahoma law requires that OCSRI inform you that your health information used or disclosed as described in this Notice may include information which may indicate the presence of a communicable disease or non-communicable disease. It may also include information related to mental health.

Other uses and disclosures of your health information for a purpose not described in this Notice or required/permitted by law, *we must obtain a specific authorization from you for that use or disclosure, and you may revoke that authorization at any time.* Examples of specific authorizations may include most uses and disclosures of psychotherapy notes, marketing disclosures and sale of protected health information. We will not use or disclose your health information for fundraising activities.

OCSRI reserves the right to amend, change, or eliminate provisions in our Notice and to enact new provisions regarding the health information created, received and maintained about you. Revised Notices will be posted and available by request at OCSRI's location(s) and on our website.

If you have questions, would like additional information, or want to report a problem regarding your privacy rights, you may contact the Compliance Coordinator at 918-499-2115. You may also file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights. You will not be retaliated against for filing a complaint.

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Patient ID: _____

Patient Name: _____
First *Middle* *Last* Sex:

Date of Birth: _____ Age: _____ SSN: _____

Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Home #: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Employer: _____ Occupation: _____

Do you have an Advanced Directive? (Examples: DNR, Living Will, Power of Attorney):

☐ Yes, on File ☐ Yes, I will bring a copy ☐ No, would like more information ☐ No, not interested at this time

Primary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

Secondary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

☐ I would like to receive text message reminders (Standard text rate messaging and data rates will apply)

I assign and authorize payment for any & all services rendered to OCSRI from my insurance company or third-party payor. I agree to pay all charges not covered by my insurance including but not limited to deductibles, co-payments, and non-covered services. I hereby authorize release of pertinent information to my insurance carrier(s). This order will remain in effect until revoked by me in writing.

Signature: _____ Date: _____