SUMMIT
CANCER CARE

Patient Information and Authorizations

Doctor: Location: Chart#

Patient Name:_____ Date: _____

Birth date:_____Sex: ☐M ☐F Patient's Social Security Number:_____

Street Address:_____

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

Phone Numbers: Home:_____ Work:_____ Cell:_____

Email address:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Race: _____

Employer/Retired/Unemployed:_____

Employer's Address:_____

Spouse Name:_____Spouse's Social Security# :_____ Birth date:_____

Employer/Retired/Unemployed:_____ Work Number: _____

Employer's Address:_____ Cell Number:_____

Emergency Contact:_____ Relationship: _____

Phone Numbers Home: _____ Work: _____ Cell: _____

Do you have an Advance Directive? ☐ Yes ☐ No

PRECERTIFICATION AND REFERRALS

If your insurance company requires preadmission certification or office referrals, it is your responsibility to see that we notify your insurance company prior to all admissions or office visits. Any charges not covered as a result of non-certification will be your responsibility.

Responsible party Signature:_____ Date signed _____

Spouse signature _____ Date signed _____

Patient signature _____ Date signed _____

OFFICE FINANCIAL POLICY

INSURANCE AUTHORIZATION: I request that payment under the medical insurance program be made either to me or to the provider for any bills for services rendered to me during the effective period of this authorization. I authorize this provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims I may use.

Responsible party Signature:_____ Date signed _____

Spouse signature _____ Date signed _____

Patient signature _____ Date signed _____

I am responsible for all financial obligations of health services as a patient, spouse, or as responsible party. I am responsible for all financial obligations for the above patient, and either the patient, spouse or responsible party will be responsible for reimbursement and payment of claims from the insurance company. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility / physician in network with the insurance plan to Summit Cancer Care. If for any reason the account should become delinquent, I and or my spouse or responsible party agree to pay for all rebilling charges, collection costs, and reasonable legal fees.

Responsible party Signature:_____ Date signed _____

Spouse signature _____ Date signed _____

Patient signature _____ Date signed _____

Please remember, it is the patient's responsibility to complete and update this information as needed. Any charges incurred due to incorrect information will be the patient's responsibility.

Name of Primary Insurance Plan:_____

Please check appropriate box: ☐Group ☐Private ☐Cancer ☐Medicare Supplement ☐Medicare Advantage

Policy Number:_____ Group Number:_____

Name of Subscriber:_____ Birth date:_____

Address to mail claim:_____

Do have a primary care physician? If so, what is the name and telephone number of your primary care physician?_____

Does your primary insurance require referral numbers? ☐Yes ☐No Phone Number: _____

Does your primary insurance require pre-certification? ☐Yes ☐No Phone Number:_____

Who is your primary insurances preferred lab? _____

Name of Secondary Insurance Plan:_____

Please check appropriate box: ☐Group ☐Private ☐Cancer ☐Medicare Supplement

Policy Number:_____ Group Number:_____

Name of Subscriber:_____ Birth date:_____

Address to mail claim:_____

Does your secondary insurance require referral numbers? ☐Yes ☐No Phone Number: _____

Does your secondary insurance require pre-certification? ☐Yes ☐No Phone Number:_____

Who is your secondary insurances preferred lab? _____

Do you have prescription coverage? ☐Yes ☐No Program Name: _____

Are you a resident of a skilled nursing facility? ☐Yes ☐No Facility Phone#: _____

Facility Name and Address: _____

IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE PLEASE COMPLETE QUESTIONS BELOW:

Are you still working? ☐Yes ☐No Retirement Date: _____

Do you have an employer group health coverage? ☐Yes ☐No Number of Employees _____

Is your spouse still working? ☐Yes ☐No Retirement Date: _____

Are you covered through your spouse's insurance? ☐Yes ☐No Number of Employees _____

CHEMOTHERAPY CAN BE VERY COSTLY. PRIOR TO THE START OF TREATMENT, WE CAN PROVIDE A DETAILED STATEMENT OF THE EXPECTED COSTS. PLEASE BE SURE TO ASK FOR AN ESTIMATED COST SHEET, IF YOU HAVE CONCERNS ABOUT YOUR INSURANCE COVERAGE. THE PATIENT RESOURCE COORDINATOR IS AVAILABLE TO ASSIST YOU.

CONSENT TO RELEASE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR PRACTICE OPERATIONS

I authorize Summit Cancer Care to obtain or release any medical information necessary to provide medical services to me and / or to process insurance claims. In addition, I authorize Summit Cancer Care to release any of my medical information that is required for any health care related utilization review, quality assurance activities or other healthcare operations.

I understand medical information to be disclosed may include history and physical examinations, consultation reports, x-ray reports, discharge summaries, progress notes, laboratory tests and photographs, videotapes, digital or other images.

I am aware and specifically waive any privilege regarding the following information that may or may not be contained in my medical record:

- Communications between patient and psychiatrist
- Communications between patient and psychologist
- Medical information concerning drug dependency
- Medical information concerning alcohol and drug dependency
- Medical information concerning alcohol and drug abuse
- Medical information concerning mental retardation
- Medical information concerning HIV / Acquired Immune Deficiency Syndrome

I further understand that in an effort to contact me regarding test results or follow-up appointments, messages may be left by the staff or my physician on voicemail or may be given to the person answering my contact number.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. A photocopy of this consent shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this consent. I acknowledge that I have received a copy of "Notice of Privacy Practices" which outlines how medical information may be used and disclosed as well as how I might obtain an explanation as to what entities my information has been released.

Following is a list of name/s of any family members, friends and/or significant other who may discuss my care with my physician or other clinical staff and receive information concerning my diagnosis and treatment with or without me present during the discussion.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Date_____ Signature_____
(Patient or Authorized Individual)

Witness_____ Relationship_____

SUMMIT
CANCER CARE

Patient History Information

Patient Name _____ Date _____

Date of Birth _____Age_____ Chart Number_____

Current Problem

Why are you here today? Describe your chief complaint / symptoms.

_____

_____

_____

Who referred you to our office? _____

Who is your primary care doctor? _____

Do you regularly have annual physicals? _____When was your last physical? _____

Which doctor did you see? _____

How would you describe you health? ☐Good ☐Fair ☐Poor

General Information

What are your hobbies?

_____

_____

_____

What is the highest level of education attained? ___ No high school diploma ___ High school diploma
___Some college ___ College Graduate ___ Masters or higher

What is your religious preference? _____

Medical

Check only the ones which apply. Fill out the date and how old you were at the time and if you were treated.

Check if applicable	Problem	Age	Date	Treated?
	Anemia/blood disorders			
	Anxiety			
	Arthritis/Rheumatism			
	Asthma			
	Atrial fibrillation			
	Benign prostatic hypertrophy			
	Cancer, _____			
	Chronic obstructive pulmonary disease			
	Congestive heart failure			
	Coronary artery disease			
	Depression			
	Diabetes type I			
	Diabetes type II			
	Diverticulosis			
	Gastroesophageal reflux disease			
	Hepatitis A			
	Hepatitis B			
	Hepatitis C			
	Hyperlipidema			
	Hypertension			
	Hyperthyroidism			
	Hypothyroidism			
	Kidney stones			
	Osteoporosis			
	Peripheral neuropathy			
	Peripheral vascular disease			
	Seizure			
	Stroke			
	Other, _____			

Procedure / Surgical

Check only the ones which apply. Fill out the date and how you were at the time.

Check if applicable	Procedure / Surgical	Age	Date
	AICD placement		
	Appendectomy		
	Thoracentesis		
	Breast biopsy		
	Breast implant		
	Caesarean section		
	Bone marrow/stem cell transplant		
	Bronchoscopy		
	Colonoscopy		
	Colon resection		
	Cholecystectomy		
	Splenectomy		
	Coronary artery bypass		
	Hernia repair		
	Hysterectomy		
	Laminectomy		
	Mastectomy		
	Pacemaker placement		
	Paracentesis		
	Tonsillectomy		
	Tubal ligation		
	Tram flap		
	TURP		
	Vasectomy		
	Other, _____		

Gynecologic (females only)

Pregnancies	enter info
How many pregnancies?	
How many deliveries?	
Age at First Birth	
# Interrupted Pregnancies	

Menses	enter info
Menses start age	
Last menstrual period	
Menstrual cycle length	

Age at menopause

Reason for menopause	check one
Chemotherapy	
Natural	
Other	
Removal of ovaries	
Removal of uterus	
Surgical	
Total Hysterectomy	

Gynecologic (continued)

Menopause status	check one
Pre	
Peri	
Post	
Unknown	
No answer	

Hormone Use	#Years used
Any Hormone Use	
Contraceptive Hormone use	
Post-menopause Use	
Other Hormone Use	

Last Tests	date
PAP	
Mammogram	

Family History

Family History	Alive Deceased Unknown	Age	Medical problems
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			

Siblings / Other family

List relationship			

How many sister(s) do you have? _____

How many brother(s) do you have? _____

Social History - Activities

Activities

Smoking	**Check if applicable**
Yes – current every day smoker	
Yes – current some day smoker	
Yes – smoker	
Yes – but quit	
Never	
Current status unknown	
Unknown if ever smoked	

Smoked for how many years? ____

How many packs per day? Circle one

.5 1 1.5 2 2.5 3

How many years since you quit? ____

Alcohol Consumption	**Check if applicable**
Yes – current every day drinker	
Yes – current some day drinker	
Yes – active	
Yes – but quit	
Never	
Current status unknown	
Unknown if ever drank	

How many days a week do you drink? __

How many drinks a day do you drink? __

How many years since you quit? ____

Hazard Materials	**circle one for each**		
Asbestos	contact	No contact	Unknown
Benzene	contact	No contact	Unknown
Lead	contact	No contact	Unknown
Radiation	contact	No contact	Unknown
Other petroleum products	contact	No contact	Unknown
Fertilizer / pesticide	contact	No contact	Unknown

Products	**Check if applicable**
Cigarettes	
Cigars	
Chewing tobacco	
Pipe	
Snuff	
Recreational drug use	
Illicit drug use	
Alcohol	

Social History – Personal / Environment

Marital Status: circle one
single married divorced widow

Occupation: _____

How many people live at your house?_____

What is their relation to you?

_____

Check if applicable	Activity
	Sedentary
	Daily activities
	Occasional exercise
	Light exercise
	Regular exercise
	Extensive exercise

Check if applicable	Support Systems
	Lives with family
	Lives alone
	Lives in a nursing home
	Lives in an assisted living environment
	Incarcerated
	Supportive family/friends willing to assist with needs
	Transportation problems exist and will require assistance
	Referred to social services for assistance
	Homeless

Check if applicable	Nutrition
	Regular meals
	Nutritional supplements
	Liquid diet
	Diabetic diet
	Vegetarian
	Kosher diet

Do you have any drug allergies? ☐Yes ☐No If yes, what are you allergic, what was your reaction, and when did this reaction occur?

List name of drug or food allergy	What type of reaction	Date

List all medication/s, vitamins, supplements or herbal medications you are currently taken. _____
_____
_____
_____
_____

Review of Systems

Please √ only the problems you are experiencing.

Constitutional
___ appetite *
___ fatigue *
___ fever
___ lethargy
___ malaise
___ night sweats
___ chills
___ weight change
Other _____

Allergic/Immunologic
___ Have you had a recent allergic reaction?
To what?_____
_____
_____
_____
_____

Ear, Nose, Mouth, Throat
___ difficulty swallowing
___ ear pain *
___ nose bleeds
___ painful swallowing
___ hard of hearing
___ dry mouth
___ oral bleeding
___ sinus congestion
___ mouth soreness
___ altered taste
___ ringing in the ears
Other _____

Eyes
___ blurred vision
___ double vision
___ excessive tearing
___ dry eyes
Other_____

Skin
___ hair loss
___ blisters
___ dry skin
___ nail changes
___ itching
___ rash
Other _____

Breasts
___ mass
___ nipple discharge
___ nipple change
___ pain *
Other _____

Cardiovascular
___ palpitations
___ chest pain *
___ swelling
___ need to sit up to breathe
Other _____

Respiratory
___ cough
___ shortness of breath
___ coughing up blood
___ hiccoughs
___ stabbing chest pain
___ wheezing
Other _____

Gastrointestinal
___ abdominal pain
___ constipation *
___ diarrhea *
___ heartburn
___ throwing up blood
___ bloody stool
___ black stool
___ nausea *
___ vomiting *
___ dehydration *
Other _____

Genitourinary
___ burning urination
___ frequent urination
___ blood in urine
___ loss of bladder control
___ increased nighttime urination
___ sexual function
___ urgency
Other_____

Musculoskeletal
___ joint pain *
___ joint swelling
___ arm pain *
___ leg pain *
___ upper back pain *
___ lower back pain *
___ muscle weakness
___ muscle tenderness
Other_____

Psychiatric
___ anxiety
___ mood swings
___ depression
___ insomnia
Other
_____

Neurologic
___ dizziness
___ difficulty walking
___ headache
___ memory loss
___ weakness
___ numbness *
___ paralysis
___ seizure
___ tingling * Other_____

Endocrine
___ hot flashes
___ menstrual irregularities
Other _____

Hematological / Lymphatic
___ easy bruising
___ tender or enlarged lymph nodes
Other _____

Any other problems?_____
_____
_____
_____

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CANCER CARE

Financial Policy & Procedures

To Our New Patients...

As you are well aware, the medical insurance industry is changing rapidly. It is vital that you keep us updated on your insurance coverage. We will need to know if your insurance company requires any precertification, preauthorization, referral numbers, or special designated hospitals for tests and hospitalization. We request that you bring your insurance cards and personal identification with you each visit so we can make copies as necessary for our records.

Co-payments are due at the time of service. Please be prepared to make payment at each visit prior to seeing your physician. You should know that health care providers such as Summit routinely contract with insurance companies to provide care to their beneficiaries. These contracts prohibit providers from waiving co-payments. Health care providers that do not follow contractual obligations are in breach of their contract and subject to insurance fraud regulations.

In addition to co-payments, you will be responsible for any insurance deductible and co-insurance. Any balance due after insurance payments will be reflected on your monthly statement. If you are unable to make full payment, please ensure you have contacted the Business Office to arrange a payment plan.

As a service to our patients, we complete forms and letters requested for work releases, disability and insurance. However, we ask that the forms or requests for letters be forwarded to the office seven to ten days before they are needed to give our staff adequate time to complete the medical information needed.

You should know that many routine laboratory tests necessary for your care are performed in our office laboratory; however, some are sent to reference labs. These lab tests may or may not be included as part of your visit. Your insurance company often determines how these are billed and paid.

It is very important that you always let us know if you have had a change in insurance or a change in where you are residing - even if your "housing" is expected to be short term such as rehabilitation or nursing home care. Billing correctly for your care will cause less stress for you and your family, as it will enable Summit to maximize your benefits and minimize your liability for costs.

To Our Patients Requiring Treatment...

The diagnosis of cancer or other blood related disorder causes a great deal of uncertainty for patients and their families. Patients have told us that one of the greatest concerns that come with these illnesses is finances as there is potential loss of income due to work absences and the full cost of treatment is many times unknown. It is our hope to at least lessen some of the uncertainty by fully addressing upfront the treatment cost for the plan of care prescribed by your

Summit physician. It is the policy of Summit Cancer Care to inform our patients of anticipated out-of-pocket costs and to establish a reasonable payment plan prior to the first treatment. Please take a moment to review our procedures outlined below, so that you are aware of our process:

- Once treatment is ordered by your physician an estimation of the costs is determined based upon drugs, dosages, and number of cycles. This is usually completed within 24 hours after the physician has ordered the treatment.

- A member of our Business Office then reviews the cost estimate and your specific insurance plan to determine how much of the estimated treatment costs is covered by your health plan and how much of the expense your plan requires to be paid by you. This is usually done within 48 hours after the treatment has been ordered.

- If your health plan requires you cover some costs, then one of our Business Office Representatives will contact you – either by phone or mail - once the assessment is completed to communicate the expected patient balance.

- This representative will provide a Patient Liability Estimate to you and request a partial payment for the total treatment. She will also request that you agree to and sign a payment plan that will detail the percentage of the patient balance to be paid each month.

It is important to know that the estimate we provide is based upon the information that is known to us at the time of your treatment order. Exact fees may differ due to changes in your condition, insurance coverage, or various other factors.

If you find you cannot make the initial payment, Summit will work with you to explore other resources that may be available. This will require that you promptly provide personal financial information to us so that we can determine if you meet eligibility requirements. Please be assured the information you provide is kept strictly confidential.

If you have any questions, please do not hesitate to contact the Business Office at 354-6187.

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Preferred Pharmacy, Laboratory and Hospital Information Sheet

Patient Name:_____ Account #: _____

Preferred Pharmacy: _____

Preferred Laboratory: _____

Preferred Hospital: _____

Please remember, it is the patient's responsibility to complete and update this information as needed. Any charges incurred due to incorrect information will be the patient's responsibility. Thank you.

Signature: _____

Date: _____

Lewis Cancer & Research Pavilion
225 Candler Drive, Suite 300
Savannah, GA 31405
T (912) 354-6187
F (912) 355-0596

Anderson Cancer Institute
4700 Waters Ave, Suite A
Savannah, GA 31404
T (912) 354-6187
F (912) 354-6765

Fair Road Professional Building
16741 Hwy 67, South, Suite B
Statesboro, GA 30458
T (912) 871-8837
F (912) 871-5295

Medical Office Building
8 Okatie Center Blvd. South
Okatie, SC 29909
T (843) 705-4848
F (843) 705--4849

SUMMIT
CANCER CARE

Consent for Release of Medical Information

I herby authorize Summit Cancer Care to release or receive information for the medical records of:

Patient Name _____
Date of Birth _____ Social Security Number _____
Requested by _____Phone Number _____
Purpose or Need for Information _____
_____
_____
_____

I authorize Summit Cancer Care to obtain or release any medical information necessary to provide medical services to me and / or to process insurance claims. In addition, I authorize Summit Cancer Care to release any of my medical information that is required for any health care related utilization review, quality assurance activities, general healthcare operations or for the purpose specified above.

I understand medical information to be disclosed may include history and physical examinations, consultation reports, x-ray reports, discharge summaries, progress notes, laboratory tests and photographs, videotapes, digital or other images.

I am aware and specifically waive any privilege regarding the following information that may or may not be contained in my medical record:

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- Medical information concerning alcohol and drug abuse
- Medical information concerning mental retardation
- Medical information concerning HIV / Acquired Immune Deficiency Syndrome

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Date _____ Signature _____
(Patient or Authorized Individual)
Witness _____Relationship _____