Blood and Cancer Center Inc.

A Regional Referral Center

CLINICAL HEMATOLOGY
MEDICAL ONCOLOGY

Antoine E. Chahine, M.D
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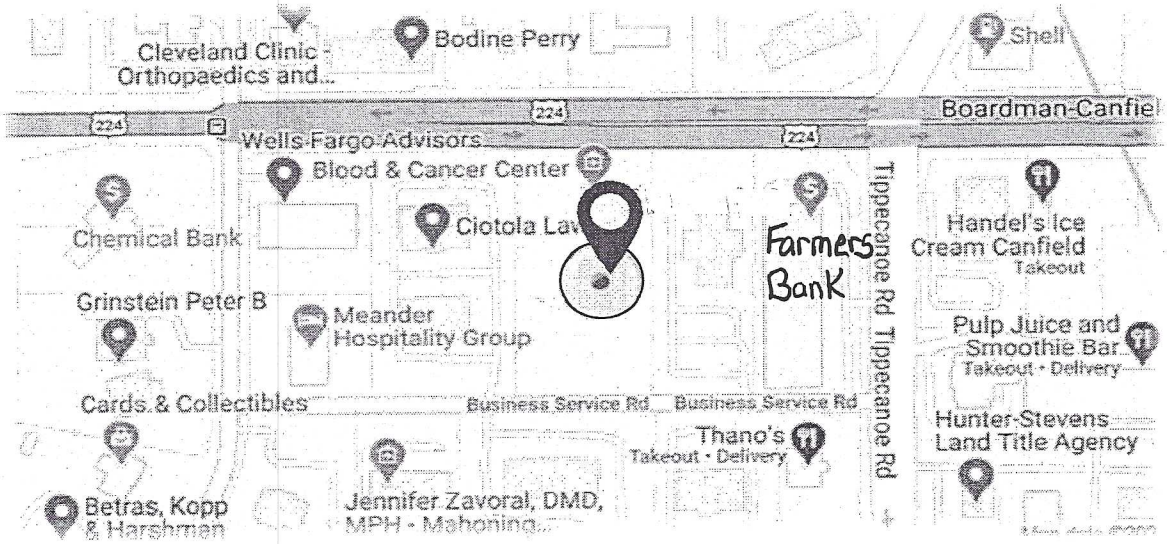
3695A BOARDMAN-CANFIELD RD. CANFIELD OHIO, 44406
PH: 330-533-3040 FX: 330-533-9459



You have been referred to our facility by Dr. _____.

You are scheduled to see Dr. _____ on

_____ at _____.

*Please arrive 15 minutes prior to your appointment time with the following:
1.) All current insurance cards,
2.) Any co-payment due at the time of your visit, and
3.) Bottles or a currently list of all medications you are taking.

Failure to bring these items will result in your appointment being rescheduled.
Please fill out the 3 registration forms enclosed in this packet to the best of your ability.
Please call the office if you have any further questions.

Thank you!

Blood and Cancer Center

○ Dr. Chahine ○ Dr. Graham ○ Dr. Verma

D.O.B: ____/____/____ Account No.: _____

Patient Name: _____
First, MI and Last Name

Address: _____

(____)_____-_____ _____-_____-_____
Home No. *Social Security No.*

(____)_____-_____ _____
Cell-Phone No. E-mail Address

Emergency Contact(s): _____
Name, No. and relation

Referring Physician: _____

Family Physician: _____

Employers Name: _____ Ph: (____) _____-_____
Address: _____

Retail Pharmacy: _____ Ph: (____) _____-_____
Address: _____

Mail in Pharmacy: _____ Ph: (____) _____-_____
Address: _____

Preferred Hospital _____

REQUIRED FOR GOVERNMENT REPORTING:

○ Hispanic ○ Non-Hispanic Living Will: ○ Yes ○ No

Power of Attorney: ○ Yes ○ No D.N.R: ○ Yes ○ No

Authorization: I hereby authorize the above physicians(s) to release any information acquired in the course of examination and or treatment or services rendered to/for me that is needed to process claims to Medicare or other carriers. I allow a photocopy of my signature to be used. I hereby authorize payment of benefitis due to me to be made directly to THE BLOOD AND CANCER CENTER INC. - ANTOINE E. CHAHINE, MD., JOHN J. GRAHAM, MD., VAIBHAV VERMA, MD. for services rendered to me. I understand that I am financially responsible for these charges. I hereby acknowledge that I have read the above and hereby affix my signature.
I have received NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS FOR PRESCRIPTION MEDICATIONS

Signature of Patient: _____ Date: _____/_____/_____

Blood & Cancer Center

Statement of Assignment of Benefits, Financial Responsibility, Consent for Purposes of Treatment, Payment and Healthcare Operations, Acknowledgment of Receipt of Notice of Privacy Practices, and Authorization for Use or Disclosure of Protected Health Information, Patient Grievance

Assignment of Benefits

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Workers' Compensation, or any other governmental or private insurance or health plans to the Blood & Cancer Center, Inc. 3695A Boardman-Canfield Rd., Canfield, Ohio 44406. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Financial Responsibility

I understand that I am responsible for all charges, whether or not I have insurance. In the event that I have insurance with a plan that has a participation agreement with the Blood & Cancer Center, I understand that I am responsible for all deductibles, co-payments and coinsurances. In the event that I do not have insurance with a plan that has a participation agreement with the Blood & Cancer Center, I understand that I am responsible for the full difference between the Blood & Cancer Centers' billed charges and the amount paid by insurance.

Consent to Use Protected Health Information of Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by the Blood & Cancer Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Blood & Cancer Center. I understand that diagnosis or treatment of me by the Blood & Cancer Center my be conditioned upon my consent as evidenced by my signature on this document. I acknowledged that I have received a copy of the Blood & Cancer Center Notice of Privacy Practices.

Patient Grievance

I understand I have the right to file grievance/complaints about my service/care verbally or written to: The Blood and Cancer Center 3695A Boardman-Canfield Road, Canfield, Ohio 44406 or call 330-533-3040.

Authorization for Application of Patient Assistance

I authorize the Blood & Cancer Center to apply for any and all patient copay assistance program(s) on my behalf to help cover the cost of my treatment. I authorize the billing office to be listed as a patient advocate in the completion of this application(s).

Authorization for Use or Disclosure of Protected Health Information

❑ I do not authorize the Blood & Cancer Center physicians and/or administrative and clinical staff to use or release the following protected health information for the purpose listed below.

❑ I do authorize the Blood & Cancer Center physicians and/or administrative and clinical staff to use the following protected health information:

- ❑ **entire record**
- ❑ problem list
- ❑ medication list
- ❑ list of allergies
- ❑ immunization records
- ❑ most recent history
- ❑ most recent discharge summary
- ❑ lab results (please describe the dates or types of lab tests you would like disclosed):
- ❑ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ❑ consultation reports from (please supply doctors names):
- ❑ other (please describe):
- ❑ disclose the following protected health information to: (Please check all that apply and describe):

❑ My Spouse _____

❑ My Family Members _____

❑ Patient's Non-Custodial Parent _____

❑ Other _____

This protected health information is being used or disclosed for the purpose of expediting communication of my treatment and care.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contract at: The Blood & Cancer Center, 3695A Boardman-Canfield Rd., Canfield, Ohio 44406. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the issuer has a legal right to contest a claim.

This authorization shall be in force and effect from the date recorded below, unless revoked by written notification from patient or personal representative of authority.

_____
Date

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT NAME: _____ D.O.B: _____/_____/_____

MARITAL STATUS: _____MARRIED ,_____SINGLE, _____WIDOWED, _____DIVORCED

HEIGHT: _____ WEIGHT: _____

LIVES WITH: _____, _____ INDEPENDENT, _____ DEPENDENT

COMMUNICATION: _____ READS, _____ WRITES, _____ UNDERSTANDS ENGLISH

HABITS, TOBACCO: _____ CURRENT, _____FORMER, _____NEVER

HABITS (CONT.), _____ ALCOHOL, _____ CAFFEINE

OCCUPATION/RETIRED FROM: _____

HEALTH HISTORY

MEDICAL HISTORY:
EXAMPLE(S): DIABETES, HEART, ETC...

1.)
2.)
3.)
4.)

SURGICAL HISTORY:

1.)
2.)
3.)
4.)

VISION:

_____ GLASSES
_____ CONTACTS

HEARING:

_____ NORMAL
_____ HARD OF HEARING
_____ HEARING AID

AIDS AT HOME:

_____ CRUTCHES
_____ CANE
_____ WALKER
_____ WHEELCHAIR

OTHER:

_____ PROSTHESIS
_____ DENTURES
_____ OXYGEN
_____ RECEIVE(D) RADIATION
_____ RECEIVE(D) CHEMOTHERAPY

DIET: _____ REGULAR, _____ SPECIAL, _____ BOWEL, _____ BLADDER

ALLERGIES: NAME **EXAMPLE*: SULFA*	**REACTION:** *HIVES*	**SEVERITY** *MILD / MODERATE / SEVERE*
1.)	1.)	1.)
2.)	2.)	2.)
3.)	3.)	3.)

CONTINUED ONTO NEXT PAGE...

PATIENT NAME: _____ D.O.B: _____/_____/_____

ALLERGIES CONTINUED,

NAME:	**REACTION:**	**SEVERITY**
**EXAMPLE*: SULFA*	*HIVES*	*MILD / MODERATE / SEVERE*
4.)	4.)	4.)
5.)	5.)	5.)
6.)	6.)	6.)
7.)	7.)	7.)
8.)	8.)	8.)

MEDICATIONS: NAME	**DOSAGE:**	**INSTRUCTIONS**
**EXAMPLE*: ASPRIN*	*81MG*	*1 TABLET DAILY*
1.)	1.)	1.)
2.)	2.)	2.)
3.)	3.)	3.)
4.)	4.)	4.)
5.)	5.)	5.)
6.)	6.)	6.)
7.)	7.)	7.)
8.)	8.)	8.)

ATTACH A LIST OF ALL CURRENT MEDICATIONS, IF EASIER THEN WRITING OUT

VACCINES	**DATE ADMINISTERED**	**LOCATION/PHYSICIAN**
_____ FLU	/ /	
_____ PNEUMONIA	/ /	
OTHER		
	/ /	
	/ /	

FOR PRESCRIPTION MEDICATIONS ONLY

YOU HAVE THE RIGHT TO:

•Be fully informed in advance about services/care to be provided, including the company representatives that provide care/services, and the frequency of visits as well as any modifications to the service/care plan.

• Be treated, and have your property treated, with dignity, courtesy and respect, recognizing that each person is a unique individual.

• Be informed both orally and in writing, in advance of care being provided of the charges, including payment for care/services expected from third parties and any charges for which the patient will be responsible

• Receive information about the scope of services that the organization will provide and specific limitations on those services

• Participate in the development and revision of the plan of care

• Refuse care or treatment after the consequences of refusing care or treatment are fully presented

• Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property

• Voice grievances/complaints regarding treatment of care, lack of respect of property, or recommend changes in policy, personnel, or services without restraint, interference, coercion, discrimination, or reprisal

• Have complaints regarding treatment or care, or lack of respect of property investigated

• Confidentiality and privacy of all information contained in the patient record and of protected health information

• Be advised on agency's policies and procedures regarding the disclosure of clinical records

• Choose a health care provider

• Receive appropriate care without discrimination in accordance with physician orders

• Be informed of any financial benefits when referred to an organization

• Be fully informed of one's responsibilities

CUSTOMER RESPONSIBILITIES:

• Adhere to the plan of treatment or service established by your physician.

• Adhere to the company's policies and procedures.

• To submit any forms that is necessary to participate in the program, to the extent required by law.

• Participate in the development of an effective plan of care/treatment/services.

• Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide care/services.

• Provide any necessary forms and documentation needed to participate in patient management programs, to the extent required by law.

• Ask questions about your care, treatment and/or services, or to have clarified any instructions provided by company representatives.

• Communicate any information, concerns and/or questions related to perceived risks in your services, and unexpected changes in your condition.
• Be available at the time deliveries are made and to allow The Blood and Cancer Center representatives to enter your residence at reasonable times to repair or exchange equipment or to provide services.
• Notify the company if you are going to be unavailable.
• Treat company personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
• Provide a safe environment for The Blood and Cancer Center representatives to provide services.

• Care for and safely use medications, supplies and/or equipment, according to instructions provided, for the purpose it was prescribed and only for/on the individual for whom it was prescribed.
• Communicate any concerns about your/caregiver's/family member's ability to follow instructions or use the equipment provided.

• Protect equipment from fire, water, theft or other damage. You agree not to transfer or allow your equipment to be used by any other person without prior written consent of the company and further agree not to modify or attempt to make repairs of any kind to the equipment. Modifying equipment or attempting equipment repairs releases the company from any liability related to the equipment and its uses, and from any resulting negative customer outcomes.
• Except where contrary to federal or state law, you are responsible for equipment rental and sale charges which your insurance company or companies do not pay. You are responsible for prompt settlement in full of your accounts unless prior arrangements have been approved by company administration.
• The company should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify the company immediately of any address or telephone changes whether temporary or permanent.

GRIEVANCES AND COMPLAINTS:

• You have the right to raise complaints with the dispensary verbally or in writing by contacting any one of the parties below:

- •THE BLOOD AND CANCER CENTER DISPENSARY STAFF (330) 533-3040
- • ACHC – Credentialing Organization (855-937-2242)
- • Ohio State Board of pharmacy

Telephone: (614) 466-4143
Fax: (614) 752-4836
TTY/TDD Ohio Relay Service: 1 (800) 750-0750
Monday -Friday 8:am to 5:00 pm EST