# 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 #: |
| | ☐ Male ☐ Female ☐ Other: _____ |
| | Please mark preferred contact number: |
| Mailing address: | ☐Home phone: |
| (if different) | ☐Cell phone: |
| | ☐Work phone: |
| Email Address: | |
| Place of Work: | Employer Phone: |
| Highest grade completed: ☐ Grade School ☐ High School ☐ College ☐ Graduate School | |
| Race/ Ethnicity: | |
| Preferred language: | |

| **Advance Directives:** | | | | |
|---|---|---|---|---|
| Do you have a living will? | ☐ Yes | ☐ No | ☐ Not sure | ☐ Would like more information |
| Do you have a power of attorney? | ☐ Yes | ☐ No | ☐ Not sure | ☐ Would like more information |
| Do you have a DNR (Do Not Resuscitate)? | ☐ Yes | ☐ No | ☐ Not sure | ☐ Would like more information |

| **Insurance Information:** | | | |
|---|---|---|---|
| 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 | | | |

| **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 #: |
|---|---|---|

| **Healthcare Questionnaire** |
|---|
| Describe your current problem in your own words. Why were you referred to us? What medically bothers you? How and when did it start? |
| |
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| |

List any **medical problems** you have now or have had in the past. Continue on the back.

| Illness | Date of Onset | Treating physician |
|---|---|---|
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Please list all **operations** that you have had, including minor surgery. Continue on the back.

| Surgery | Date | Surgeon |
|---|---|---|
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| Have you ever had any radiation therapy treatments? If no, leave blank. | | | |
|---|---|---|---|
| Area of body | Dosage | Date | Location/ physician |
| | | | |
| | | | |

| Do you have any allergies to medications or foods? Continue on the back. | | |
|---|---|---|
| Medication/ Food Allergy | Reaction | Date |
| | | |
| | | |
| | | |
| | | |

List all medications you are currently taking - **prescription** and **over the counter** medications. Continue on the back.

| Medication name | Dose | Frequency | Reason for taking |
|---|---|---|---|
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**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:_____

_____

**Healthcare maintenance**

| | | |
|---|---|---|
| ☐ Colonoscopy | Date: _____ | Facility/physician: _____ |
| ☐ Stomach scope (EGD) | Date: _____ | Facility/physician: _____ |
| ☐ Mammogram (if applicable) | Date: _____ | Facility: _____ |
| ☐ Bone density (DEXA scan) | Date: _____ | Facility: _____ |
| ☐ PSA (if applicable) | Date: _____ | Physician: _____ |

**Vaccinations**

| | | | |
|---|---|---|---|
| ☐ Influenza (flu shot) | Date: _____ | ☐ COVID-19 | Date: _____ |
| ☐ Shingles | Date: _____ | ☐ Other | Date: _____ |
| ☐ 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: ☐ yes ☐ no

Hysterectomy: ☐ yes ☐ no
Ovaries removed: ☐ yes ☐ no

| | | | | | |
|---|---|---|---|---|---|
| ☐ Birth control: | ☐ yes | ☐ no | Type:_____ | # of years use: _____ | Year stopped: _____ |
| ☐ Hormones: | ☐ yes | ☐ 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):

☐ Home/ Cell #: _____
- ☐ Do not leave a message at this number
- ☐ Ok to leave a message with details
- ☐ Ok to leave message with call-back number only

☐ Work Telephone: _____
- ☐ Do not leave a message at this number
- ☐ Ok to leave a message with details
- ☐ Ok to leave message with call-back number only

☐ Fax (if available): _____
- ☐ 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

**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 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.***