**Emerald Coast Cancer Center**
**1024 Mar Walt Drive**
**Fort Walton Beach, FL 32547**

**New Patient Information Form - Please Print Legibly**

Today's Date: ______________________

Patient's Name: ______________ Date Of Birth: ______________

Home Address: ______________ Social Security #: ______________

______________

______________ Male or Female ______________

Mailing Address: ______________ Home Phone #: ______________

(If not same as Home) ______________ Mobile Phone #: ______________

______________ Work Phone #: ______________

Marital Status

Single ______ Married ______ Divorced ______ Separated ______

Widow ______ Significant Other ______

Email Address: ______________________

Place of Work ______________ Employer Phone # ______________

Did you graduate from: ______ Grade School ______ High School ______ College ______ Graduate School ______

**Advance Directives**

Do you have a living will? Yes or No

Do you have a power of attorney? Yes or No

Do you have a DNR "Do not resuscitate"? Yes or No

**Insurance Information**

Primary Insurance ______________ Employer ______________

Policy # ______________ Group Number ______________

Policy Holder Name ______________ Policy Holder SSN ______________

Policy Holder Date of Birth ______________

Secondary Insurance ______________ Employer ______________

Policy # ______________ Group Number ______________

Policy Holder Name ______________ Policy Holder SSN ______________

Policy Holder Date of Birth ______________

Referring Doctor ______________________

Telephone # ______________ Address(if not local) ______________

Name Other Doctors

Physician Name: ______________ Telephone #: ______________

Physician Address (if not local): ______________________

Physician Name: ______________ Telephone #: ______________

Physician Address (if not local):

Describe your current problem in your own words: What medically bothers you? How and When did it start? Why are you referred to us?

Due to the nature of our specialty, we require a rather detailed history from our patients. The information requested below will be kept in the strictest confidence. Please be as thorough as possible so that we can provide you with the best possible care.

Please list all operations that you have had, including minor surgery:

Operation ______ Date ______ Surgeon ______

Operation ______ Date ______ Surgeon ______

Operation ______ Date ______ Surgeon ______

Operation ______ Date ______ Surgeon ______

Operation ______ Date ______ Surgeon ______

Have you every had Radiation Therapy treatments? If so, please list the date, amount/duration of therapy, the area of body that was radiated, and the name of the Radiotherapy center.

Area of Body ______ Date ______ Dosage ______ Radiotherapy Center ______

Area of Body ______ Date ______ Dosage ______ Radiotherapy Center ______

List all medications you are currently taking: Prescriptions, Over the Counter Medications, Vitamins, and etc…

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

Medication Name ______ Dose ______ (MG) Frequency ______
Reason Taken ______

(IF YOU HAVE MORE MEDICATIONS TO LIST, PLEASE LIST THEM ON THE BACK OF THIS PAGE)

Please provide your Pharmacy name and phone number for our records.

Pharmacy ______________________ Phone Number ______________________

Have you ever had an adverse reaction or allergic reaction to any medication or food? If so, Please list the agent and describe the reaction. If not, please write *"Never".*

List any medical problems you have now or have had in the past. (I.E. Diabetes, Ulcer, Heart Disease, Bleeding Problems)

| Illness | Date of Onset | Treating MD |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |

Have you ever been treated with hormones? ______________________

Were you ever exposed to toxic chemicals? ______________________

Have you traveled outside the U.S.? ______________ If so, Where? ______________

Have you ever had Tuberculosis (TB) ? ______________ Has anyone close to you ever had TB? ______________

Have you ever had a problem with drugs or alcohol? ______________________

If so, Describe: ______________________

Do you drink alcohol now? ______________ If so, how much? ______________

Do you drink coffee or tea? ______________ If so, how much? ______________

Have you ever smoked? ______________ If so, how much? ______________

Have you quit smoking? ______________ If so, when? ______________

Have you ever had a blood transfusion? ______________________

Please describe the circumstances: ______________________

Have you ever had a reaction to a blood transfusion? ______________________

Have you ever had psychiatric treatment or psychiatric hospitalization? ______________________

If so, please describe: ______________________

Have you ever take psychoactive medications? ______________________

If yes, please describe: ______________________

**Family History**

Has anyone in your family ever had cancer? __________

If so, List relationship to you and type of Cancer? __________

Is your mother alive? __________

If not, what did she die from and what age? __________

Does/Did she have any medical problems? __________ List Here: __________

Is your father alive? __________

If not, what did he die from and what age? __________

Does/Did she have any medical problems? __________ List Here: __________

How many brothers and sisters do you have? __________

Please list all serious illnesses that any of them has had __________

How many children do you have? __________

Please list all serious illnesses that any of them has had __________

**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

**Harvey Y. Hsiang, M.D., PhD**
**Y. Henry Hsiang, M.D., PhD**
**Melissa King, M.D.**
**Tiffany Connors, ARNP**
**Deborah Hewitt, ARNP**
**Courtney Loper, PA-C**
**Brittany Booker, ARNP**

## REQUEST FOR RELEASE/REQUEST OF MEDICAL RECORDS

**Please Sign This Page 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.**

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**Date of Birth:** ______________________________

**Patient Name Printed:** ______________________________

**Patient Signature:** ______________________________

# Emerald Coast Cancer Center

## Appointment Guidelines

Since providing quality treatment for all our patients, in a timely manner is a major focus of our practice philosophy, and because last minute cancellations can cause hardships for many individuals, we would like to clarify our appointment guidelines.  It is our sincere hope you will accept these guidelines and join us in our efforts to provide quality time for you and each value patient in our practice.

1.  Please give us a 24 hour notice to cancel an appointment otherwise there is a $25 cancellation fee.  If you have an emergency please let us know and we will see if we can waive the fee.  If you consistently miss an appointment or cancel at the last minute we will have no choice but to disengage you from the practice.

2.  Patients who habitually do not show up for appointments may be required to pay reservation fee to make future appointments.

3.  Patients who are fifteen (15) minutes late to a scheduled appointment may not receive all scheduled treatment and / or may be asked to reschedule the entire appointment.

I have read and understand the above information listed.

**Patient Signature:** ______________________________

**Patient Name:** ______________________________

**Date:** ______________________________

# Financial Information and Health Insurance

After your first consultation with the doctor, our business office personnel will explain our billing and insurance filing procedures. During the course of your care, any problems or questions you may have concerning your account or insurance may be addressed to them.

## Insurance Patients:

We file insurance claims as a *courtesy and convenience* for our patients. Some insurance companies will make payments directly to the insured. If this is the case with you insurance company, you will be responsible for charges at each visit. If you insurance company pays directly to us within 30 days as required by the Florida State Insurance Commissioner, you need only pay applicable cost shares, deductibles, and any non-covered services/denials.

Since each insurance carrier has different rules and standards of coverage, it is necessary for each patient's policy to be reviewed individually. After you see the doctor today, our business personnel will review you coverage with you and explain our filing procedures. This usually takes on a few moments. Thereafter, you will stop in the insurance office after each visit to pay your cost shares. Our business manager or insurance personnel will speak to you privately and figure your payment due for that day's medical care. Often we can estimate monthly costs for your ongoing care so that you may make one monthly payment. Please let use know if you wish us to do so. Remember, since treatment, and therefore fees, may vary depending on your progress, we can only estimate monthly costs.

We would like you to be aware, that you will be responsible for any fees denied by your insurance company as not allowed unless the doctors are participating providers (accepts assignment) with your primary insurance company.

Should you ever have any problems or questions concerning your account, please feel free to call or come in and discuss them with us.

The release form on the following page is standardized to cover most insurance companies' requirements. Please read and sign this form if you wish us to file insurance claims for you, and to assign benefits to this office.

# Private Pay Patient

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*** . You may pay cash, check, or with credit card. 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.

I prefer to pay cash, check or credit card for any office charges. Bills and receipts will be provided to me if necessary 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 #: ______________________________

# Lifetime Authorization

## Insurance Assignments and Authorization to Release Information

I. **Release of Information -** I hereby authorize Harvey Y. Hsiang, MD, PhD, Y. Henry Hsiang, MD, PhD, and/or his 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 Harvey Y. Hsiang, MD, PhD, Y. Henry Hsiang, MD, PhD, and/or his authorized employees to file insurance claims on my behalf to all applicable third payers. I hereby assign all benefits due directly to Harvey Y. Hsiang, MD, PhD or Y. Henry Hsiang, MD, PhD. 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 Harvey Y. Hsiang, MD, PhD., Y. Henry Hsiang, and/or his 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 to Harvey Y. Hsiang, MD, PhD. or Y. Henry Hsiang MD, PhD 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.

**Date:** ______________________________

**Patient Name:** ______________________________

**Policyholder/Guarantor:** ______________________________

**Policyholder/Guarantor Address:** ______________________________

**Policyholder/Guarantor Home #:** ______________________________

**Policyholder/Guarantor Work #:** ______________________________

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## FINANCIAL QUESTIONNAIRE FOR DRUG REPLACEMENT AND COPAY ASSISTANCE

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:** ______________________________ **Date Of Birth:** ______________

**How many in household?:** ______________________________

**What is total income that was claimed on most recent tax return?: (if income has changed from amount claimed please provide new income amount.)**

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

**Please initial in box if you choose to 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 COMPLETED YEARLY.***

**Emerald Coast Cancer Center**
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**Fort Walton Beach, FL 32547**

**HIPAA Consent**

**Patient Name:** ______________________________

*Patient Record of Disclosures*

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, 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 Telephone ______________________

_____ OK to leave a message with details _____ Leave message with call-back number only

_____ OK to fax to this number

_____ Work Telephone ______________________ or Work Fax ______________________

_____ OK to leave a message with details _____ I give authorization for Emerald Coast Cancer Center to leave a message

_____ Leave message with call-back number only my absence _____ OK to send fax to work fax number

_____ Cell Phone ______________________

_____ OK to leave a message with details _____ My appointment reminders

_____ Leave message with call-back number only _____ my account such as billing and amount due

_____ my treatment/test results

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 # ______________

Name ______________________ Relationship ______________ Phone # ______________

Patient Signature: ______________________________ Date ______________

FEMALE PATIENT FORM

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*Please fill out the following form in order to assist us with the move to our new medical records system.*
*Thank You.*

**Patient Name:** ____________________ **Date Of Birth:** ____________

## Tobacco Use and Cessasion Counseling

### *Tobacco Use*

_____ Non Smoker _____ Current Every Day Smoker _____ Current Some Day Smoker _____ Heavy Tobacco Smoker

_____ Light Tobacco Smoker _____ Former Smoker _____ Pipe Smoker _____ Chews Tobacco _____ Snuff User

_____ User of Moist Powdered Tobacco _____ Never Smoker _____ Years Discontinued _____ Number of Years of Use

_____ Pack(s) Per Day _____ Pack(s) Per Year History

***Type:*** _____ Cigarettes _____ Cigars _____ Pipe _____ Smokeless Tobacco
_____ E-Cigarettes

## Smoking Cessasion Counseling

_____ N/A _____ Advised to Quit _____ Discussed Cessation Methods _____ Discussed Cessation Medications

_____ Not Discussed

## Alcohol

_____ Never _____ Current _____ Social _____ Former

*If Former Please Provide Date Stopped* ____________________

_____ Drinks Per Day _____ Drinks Per Month

**Type:** _____ Wine _____ Beer _____ Spirits

## Recreational Drug Use

_____ Yes _____ No

## Marital Status

_____ Never _____ Single _____ Married _____ Partnered _____ Separated
_____ Divorced _____ Widowed

## Children

_____ Yes _____ No If Yes, How Many Children Do You Have? _____

## Occupation/Employment

_____ Full Time Employment _____ Part Time Employment _____ Retired _____ Disabled

_____ Full Time Student _____ Part Time Student _____ Never Employed _____ Other or N/A

If currently employed please list current occupation: ____________________

If retired or disabled please list former occupation: ____________________

Secondary occupation (if applicable) ____________________

## Occupation Exposure

_____ Not Evaluated _____ No Occupational Exposure _____ Occupational Exposure

_____ N/A

If so what type of occupational exposure? ____________________

## Gynecological History

## Menstrual History

_____ Age at First Menstration _____ Age at Menopause

_____ Regular Menstral Flow _____ Irregular Mentral Flow

_____ Normal Flow _____ Light Flow _____ Heavy Flow

_____ Date of Last Menstral Period

## Maternity

_____ How Many Pregnancies _____ How Many Live Births

_____ Age at First Full Term Pregnancy

Breastfed- _____ Yes _____ No

## Hysterectomy

_____ Yes _____ No

If Yes: _____ Partial Hysterectomy _____ Complete Hysterectomy

## Hormone Use

_____ None _____ Birth Control _____ Number of Years Taken ____________ Type

_____ Continued Use _____ Year Stopped

_____ Hormone Replacement Therapy _____ Number of Years Taken ____________ Type

_____ Continued Use _____ Year Stopped ____________ Other

## Health Maintenance

## Colonoscopy

_____ Never OR _____ Date of Last Colonoscopy

Please List the Physician That Performed Your Last Colonoscopy ____________________

## Stomach Scope (EGD)

_____ Never OR _____ Date of Last Stomach Scope (EGD)

Please List the Physician That Performed Your Last Stomach Scope (EGD) ____________________

**Mammogram**

_____ Never OR _____ Date of Last Mammogram

Please List the Physician or Facility That Performed Your Last Mammogram ________________________________

**Monthly Self Breast Exam**

_____ Yes _____ No _____ Sporadic

**Pap Smear**

_____ Never OR _____ Date of Last Pap Smear

Please List the Physician That Performed Your Last Pap Smear ________________________________

**Bone Density**

_____ Never OR _____ Date of Last Bone Density

Facility Bone Density Done At: ________________________________

**Vaccination Record**

| | | | | | | |
|---|---|---|---|---|---|---|
| Influenza (Flu Shot) | _____ | Yes | _____ | No | _______________ | Date of Influenza (Flu) Shot |
| Shingles | _____ | Yes | _____ | No | _______________ | Date of Shingles Vaccination |
| Pneumovax | _____ | Yes | _____ | No | _______________ | Date of Pneumovax |
| COVID-19 | _____ | Yes | _____ | No | _______________ | Date of COVID-19 Vaccination |

Other Vaccination(s) ________________________________

________________________________________________

________________________________________________

________________________________________________

**Family History**

Mother _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death ________________________________

Father _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death ________________________________

# EMERALD COAST CANCER CENTER

## PATIENT HEALTH QUESTIONNAIRE -9
## (PHQ-9)

**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 |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself --or that you are a failure or have let yourself or family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching TV | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 ______ + ______ + ______ + ______

= **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,**

| Not difficult at all | Somewhat difficult | Very Difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |