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 _____

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1024 Mar Walt Drive
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Fax: 850-863-3132
Alt Fax: 850-862-8668

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Y. Henry Hsiang, M.D., PhD
Melissa King, M.D.
Aaron Henderson, D.O.
Deborah Hewitt, APRN-C
Courtney Loper, PA-C
Brittany Booker, APRN-C
Dianne Okonsky, APRN-C

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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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 _____

MALE 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 Cessation 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 Cessation 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? _____

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) _____

PSA _____ Never OR _____ Date of Last PSA

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 you have been moving around a lot more than usual	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, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very Difficult**	**Extremely difficult**
☐	☐	☐	☐