FORT WAYNE
MEDICAL ONCOLOGY
AND HEMATOLOGY

Welcome to our practice

Welcome to Fort Wayne Medical Oncology and Hematology. Thank you for choosing our practice and providers as part of your healthcare team. Our practice participates in the Oncology Medical Home certification provided by ASCO (American Society of Clinical Oncology) and COA (Community Oncology Alliance). We are constantly evaluating our providers and care teams to ensure we are meeting national guideline of quality; while monitoring the cost of your care. FWMOH is dedicated to ensuring access to care by addressing barriers that our patients may be experiencing.

Please be aware of our available services:

- Electronic Registration in the comfort of your own home or in our office on an IPad.
- At every visit you will be asked to show your Driver's license and insurance cards along with your co-pay if required.
- On site wheelchairs
- Flexible appointments with our providers and midlevel staff.
- Extended hours with late hours at our South office including Saturday and Sundays for your walk in needs and convenience.
- Knowledgeable phone nurses available Monday through Friday from 8:00am to 5:00pm.
- After hours on call to reach one of our physicians and or midlevel providers by using our practice phone numbers. Results are given at appointments or can be seen in the patient Portal (Carespace).
- Prescription refills are handled within 72 hours. Narcotics are not refilled on weekends or holidays.
- Follow up appointments are scheduled and electronic reminders are sent using email, voice and text. Confirming the appointment will stop continued attempts at reminding you on upcoming appointments.
- We do not participate in texting communication, however we encourage secure email through our patient portal (Carespace).

Enclosed you will find a patient history form and a statement of our financial policies. Please read and complete these forms to the best of your ability before your appointment.

We encourage you to contact your insurance company to verify your coverage, as we participate with many networks, but not all. By calling your insurance provider prior to your appointment you can find out if you are covered by out-of-network benefits. This will also prepare you for any additional testing that your provider may need to treat you.

We sincerely hope that your experience with our office is as pleasant as possible.

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Fort Wayne Medical Oncology and Hematology, Inc.

Please bring your insurance card(s) to your appointment

Patient name:_____ Date of birth:_____ Gender: ☐ Male ☐ Female

Social Security #:_____ Primary care provider: _____

Ethnicity: ☐ African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other

Race: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Identify as: ☐Him/He ☐Her/She

Gender assigned at birth: ☐Female ☐Male

Preferred language: ☐ English ☐ Spanish ☐ Burmese ☐ Sign language/ASL ☐ Other

Email address: _____

Street address: _____

City:_____ State:_____ Zip: _____

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

Employer:_____ Occupation: _____

Living Status: ☐ Lives alone ☐ Lives with family ☐ Lives in a nursing home, facility: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow / Widower

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Do you have any of the following? *If yes, please bring a copy for our records.*

☐ Living will ☐ Power of Attorney-financial ☐ Power of Attorney-healthcare ☐ Healthcare representative

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Primary Insurance Information

Name of insurance co.:_____ ID#: _____

Group number:_____ Policy holder's name:_____

Policy holder's date of birth:_____ Policy holder's Social Security number: _____

Employer: _____

Secondary Insurance Information

Name of insurance co.:_____ ID#: _____

Group number:_____ Policy holder name: _____

Policy holder's date of birth:_____ Policy holder's Social Security number: _____

Employer: _____

FORT WAYNE
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Consent to Treat and Patient Financial Policy

Consent for Care and Treatment

I, the undersigned, hereby voluntarily consent and authorize Fort Wayne Medical Oncology and Hematology, through its physicians, to perform diagnostic procedures and/or medical treatment judged necessary or advisable by the physician (s). I acknowledge that no guarantees or representation have been made to me as to the results of this treatment. The services provided are considered medically necessary, advisable and proper in the diagnosing or treatment of his/her/my condition or presenting problems. I understand that some of these services are sent to outside or non-network providers and I will receive separate billing for these outside services that may or may not be covered by my insurance.

Initial _____

Financial Policy Statement

We bill your health insurance company and you are responsible for any co-pay or deductible at the time of service. We require that payment of your estimated share be made at the time of your appointment. If you are not covered by insurance or out of network, we require a $75 minimum deposit per visit, at the time of service. Any unpaid balances will be your responsibility and payment, in full, is due upon receipt of your statement. Pre-certification by your insurer is not a guarantee of payment of benefits. If payment is made to you for services provided by Fort Wayne Medical Oncology and Hematology, you are obligated to promptly pay us for those services; if your account goes into collection status with Fort Wayne Medical Oncology and Hematology, your privileges with us will cease. We realize that temporary financial problems may arise and affect your timely payment on your account. Financial Counseling is available to evaluate options for financial assistance that may be available for medically necessary services.

Initial_____

Notice of Financial Interest in a Healthcare Entity

You are hereby notified that one or more of the physicians at Fort Wayne Medical Oncology and Hematology, Inc. have a financial interest in Dupont Hospital, LLC. You may be referred to Dupont Hospital, nevertheless, the selection of a specific healthcare entity/facility rests with the patient and you may choose an alternate entity/facility of your choice.

Initial_____

Benefit Assignment/Release of Information

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment benefits by my insurance company, Medicare, Medicaid or any other third party payer, to Fort Wayne Medical Oncology and Hematology.

Initial_____

I hereby agree to the above and foregoing and financial responsibility for services provided.

_____ Patient name, printed

_____ Date

_____ Signature of patient

_____ Signature of spouse

_____ Signature of other guardian/custodian

_____ Type of responsibility
Power of Attorney, Guardian
Provide a copy of your designation

FORT WAYNE
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Patient Rights and Responsibilities

Fort Wayne Medical Oncology and Hematology, Inc.

Through research and education, we provide compassionate, quality care in an atmosphere which provides support, respect, and dignity to our patients. Our team of physicians and staff is committed to providing state of the art care to patients with cancer and blood disorders.

- Be fully informed in advance about treatment to be provided, including the representatives who provide care, and the frequency of visits as well as any modifications to my individual care plan.
- Be treated, and have my property treated, with dignity, courtesy, and respect, recognizing that I am a unique individual.
- Be informed both orally and in writing, in advance, of care being provided, of the estimated charges, including expected payment for treatment services from third parties, and any charges for which I 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 my individual plan of care.
- Refuse care or treatment after the implications of refusing care or treatment are fully presented and explained.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of my property.
- Voice grievances and concerns regarding treatment services, lack of respect of property, or recommend changes in policy, personnel, or services without restraint, interference, coercion, discrimination, or reprisal. Concerns may be reported to:
  - FWMOH Patient Experience Officer, (260) 969-7853
  - Office of Indiana Attorney General, (312) 232-6201
  - United States Department of Health and Human Services, (877) 267-2323
  - Accreditation Commission of Health Care, (855) 937-2242
- Have complaints regarding treatment services or lack of respect investigated.
  - Grievances shall be investigated within 5 days of reporting to FWMOH and resolved within 14 days. If the grievance involves death or serious injury, investigation shall begin within 24 hours and be resolved within 3 days.
- Confidentiality and privacy of all information contained in my record and of protected health information.
- Be advised on the 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 another organization.
- Be fully informed of my responsibilities.

_____ _____

Patient signature Date

FORT WAYNE
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HIPAA Privacy Receipt Acknowledgement
Fort Wayne Medical Oncology and Hematology, Inc.

Patient Name: _____ Date of Birth:_____

The Fort Wayne Medical Oncology and Hematology (FWMOH) Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

FWMOH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me by mail or asking for one at the time of my next appointment.

☐ Accept notice ☐ Decline notice Initials: _____

I further authorize Fort Wayne Medical Oncology to communicate with me via the phone, text and email through HIPAA secure communication. Initials: _____

I authorize the following person(s) minimal access (this does not include copies of medical records) to my protected Health information (PHI):

Name	Date of Birth	Telephone number	Relationship

Emergency Contact: _____ Date of Birth: _____

Telephone number: _____ Relationship to patient: _____

Patient's signature:_____for authorization to release limited PHI to the above listed individuals.

If the patient is unable to sign, Signature of representative: _____

Type of representative/Relationship: _____

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Current Symptoms

Name: _____Date of Birth: _____

Check yes if have been diagnosed with the following:

GENERAL ☐ **None**	**Yes**	**ENDOCRINE:** ☐ **None**	**Yes**	**SKIN** ☐ **None**	**Yes**
Change in Weight		Hot flashes		Skin rash/itching	
Fatigue/Weakness		Hot & cold intolerance		Change to wart or mole	
Fever/chills		Excessive thirst		A sore that won't heal	
Night Sweats		**DIGESTIVE:** ☐ **None**		Yellowing of skin	
Frequent Colds		Nausea/vomiting		Other skin complaints	
EYES: ☐ **None**		Constipation		**NEURO SYSTEM** ☐ **None**	
Blurred/double vision		Diarrhea		Headaches	
Change in vision		Heartburn		Dizziness/lose balance	
EARS, NOSE, MOUTH: ☐ **None**		Abdominal pain/bloating		Seizures	
Hearing loss		Black/bloody stools		Confusion/memory loss	
Ringing in ears		Hemorrhoids		Fainting	
Trouble swallowing		**GENITOURINARY** ☐ **None**		Numb/tingling in extremities	
Sore Throat		Unable to hold urine		Weakness of arms or legs	
Nasal Drainage/Sinus problems		Pain/burning/Blood with urination		**PSYCHIATRIC** ☐ **None**	
Nose bleeds		***MEN ONLY…***		Work/family stress	
Bleeding gums		Impotence		Anxiety/nervousness	
Dental Problems		***WOMEN ONLY…***		Depression	
HEART: ☐ **None**		Painful intercourse		Difficulty sleeping/insomnia	
Chest Pain		Vaginal discharge		**BLOOD DISORDERS** ☐ **None**	
Heart Palpitations		Abnormal vaginal bleeding		Abnormal Bleeding	
Light Headedness		**BONES, JOINTS, MUSCLES** ☐**None**		Bruising	
Swollen feet, ankles or hands		Joint stiffness		Lumps/bumps neck or groin	
LUNGS: ☐ **None**		Back pain		**IMMUNOLOGIC** ☐ **None**	
Cough		Arthritis		Severe allergic reactions to food or medications	
Shortness of Breath		Muscle pain		Pollen allergy/hay fever	
Difficulty breathing when flat		Bone pain		Frequent/severe infections	

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Immunizations, Surgical and Past Medical History

Name:_____ Date of Birth_____

Immunizations

Check if you have had the following:

☐ Influenza/Flu ☐ Pneumonia ☐Shingles ☐ COVID ☐RSV

Surgical History

Check if you have any of the following surgeries:

☐ Appendectomy ☐ Bronchoscopy ☐ Brain Surgery ☐ Lung Surgery ☐ Cholecystectomy

☐ Bowel Resection ☐Gastric Bypass ☐Hip/Knee Replacement ☐Lumpectomy/Mastectomy

☐Implanted device ☐Kidney Removal ☐Kidney Stones Removed ☐ Thyroid Surgery ☐Hysterectomy

☐Mole/skin lesion removal ☐Heart Surgery ☐Tonsillectomy ☐Pain Procedures ☐Prostate/bladder surgery

Past Medical History

Check all that apply:

☐Unremarkable	☐Gout	☐ Nervous breakdown	***Women only***
☐Anemia	☐GERD	☐Osteoporosis/Osteopenia	☐Ovarian cyst
☐Arthritis	☐GI Bleed	☐ Poor Circulation	☐Menopause
☐Atrial Fibrillation	☐Goiter	☐ Seizure Disorder	***Family History of Cancer***
☐Blood Clots	☐Heart Murmur	☐ Stroke	☐Breast/Ovarian/Uterine
☐Breast Disease	☐Heart Attack	☐ Substance Abuse	☐Prostate
☐Cancer	☐Heart Failure	☐ Serious emotional issues	☐Pancreas
☐Cirrhosis	☐High blood pressure	☐Thyroid (over/under active)	☐Lung
☐Diabetes	☐High Cholesterol	***Men only***	☐Colon/Rectal/small bowel
☐Emphysema	☐Hepatitis	☐Prostate problems	☐Lymphoma/Leukemia
☐Glaucoma	☐ HIV	☐PSA test	☐None/Unknown/Other

Social History

Check all that apply:

Do you smoke or use: ☐Never ☐ Cigarettes ☐ E-cigarettes/Vape ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Former

Do you drink alcohol and how frequent: ☐Never ☐ Social ☐ Currently uses ☐Daily ☐ Weekly ☐ Yearly

Do you use any illicit drugs? ☐ Never ☐ Occasionally ☐ Past use, not currently

Have you had a blood transfusion? ☐Yes ☐ No

Patient's name: _____ Date of birth: _____

Medication Allergies

Medication	Type of Reaction
1.	
2.	
3.	
4.	
5.	

List All Medications / Over the Counter / Herbal and Supplements

Name of Medication	Dose	Instructions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
Preferred pharmacy/address:		
Any medications administered in another provider's office:		

List All Physicians You See

Physician Name	Specialty
1.	
2.	
3.	
4.	
5.	