Patient Name_____ **Account #** _____
Please Print TXO will complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Preferred Language _____

Circle Ethnicity Hispanic or Latino Not Hispanic or Latino

Circle Preferred Method of Contact Home Phone Cell Phone Work Phone
Email Mail Home Address

Phone number not previously provided _____ H C W (circle type)

Email address: _____

CIRCLE RACE:

AFRICAN AMERICAN	HMONG	PACIFIC ISLANDER NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	POLYNESIAN NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	SAMOAN
CHAMORRAN	KOREAN	TAHITIAN
CHINESE	LAOTIAN	THAI
FIJI ISLANDER	MELANESIAN NOS	TONGAN
FILIPINO	MICRONESIAN NOS	VIETNAMESE
GUAMANIAN NOS	NATIVE AMERICAN	UNKNOWN
HAWAIIAN	NEW GUINEAN	OTHER
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

Heather M. King, MD

Patient Name: _____ Date of Birth: _____

Today's Date: _____ MRN#: _____

Any new breast issues?

_____

_____

Any changes to your overall health?

_____

_____

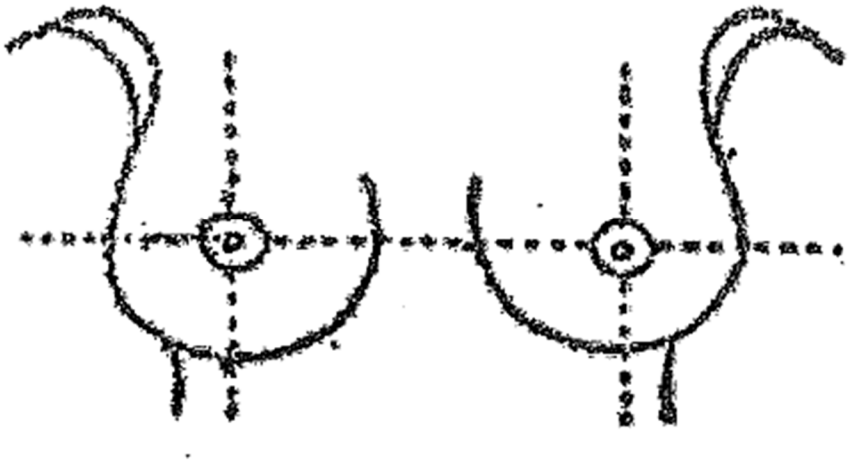
Date of most recent mammogram? _____

Any other breast imaging? _____

Referring Physician: _____

Primary Care Physician: _____

_____PLEASE DO NOT WRITE BELOW_____



Impression | Plan:

TEXAS BREAST SPECIALISTS

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Heather M. King, MD **PI**

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please indicate any symptoms you are experiencing:

General:
- ☐ chills
- ☐ fatigue
- ☐ night sweats
- ☐ weight gain ≥ 10 lbs
- ☐ weight loss ≤ 10 lbs

Skin:
- ☐ bruising
- ☐ rash
- ☐ color changes

HEENT:
- ☐ headache
- ☐ hearing change
- ☐ vision changes
- ☐ sore throat

Neck:
- ☐ mass
- ☐ lumps
- ☐ swollen glands

Female Genitourinary:
- ☐ abnormal vaginal bleeding
- ☐ menstrual irregularities
- ☐ pelvic pain
- ☐ urinary complaints

Male Genitourinary:
- ☐ lump in testicle
- ☐ penile discharge
- ☐ prostate conditions

Cardiovascular:
- ☐ chest pain
- ☐ irregular heart beat
- ☐ rapid heart beat
- ☐ swelling of extremities

Respiratory:
- ☐ chronic cough
- ☐ shortness of breath
- ☐ wheezing

Gastrointestinal:
- ☐ abdominal pain
- ☐ change in bowel habits
- ☐ constipation
- ☐ diarrhea
- ☐ nausea / vomiting

Musculoskeletal:
- ☐ muscle pain
- ☐ bone pain
- ☐ joint pain

Psychiatric:
- ☐ anxiety
- ☐ depression
- ☐ insomnia
- ☐ panic attacks

Endocrine:
- ☐ cold intolerance
- ☐ heat intolerance
- ☐ hair changes
- ☐ hot flashes
- ☐ libido changes

Hematology:
- ☐ anemia
- ☐ easy bruising
- ☐ prolonged bleeding
- ☐ enlarged lymph nodes
- ☐ nose bleeds

Neurologic:
- ☐ numbness
- ☐ weakness
- ☐ tremors

Other symptoms:

_____

_____

_____

_____

_____

_____

TEXAS BREAST SPECIALISTS

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PI

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please indicate any medical problems you have:

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Heart Disease
- ☐ Psychiatric History
- ☐ Asthma
- ☐ Reflux / indigestion
- ☐ Thyroid Problem
- ☐ Bleeding Problems
- ☐ Prior cancer (please describe below)

Any Other Medical Problems:

_____

_____

_____

Please List any Prior Surgeries:

_____

_____

_____

Social History:

Occupation: _____

Tobacco Use: ☐ Yes ☐ No Packs per day: _____ Years: _____

Alcohol Use: ☐ Yes ☐ No Drinks per week: _____

Illicit Drug Use: ☐ Yes ☐ No Describe: _____

Please give the dates of the most recent:

Colonoscopy_____ Bone Density Exam: _____

Pelvic Exam _____

Allergies to Medications:

_____

_____

_____

Medications / Vitamins / Supplements:

_____

_____

_____

Pharmacy:

Name _____

Address / Cross Streets _____

Will you allow Texas Breast Specialists to obtain your medication history electronically from your pharmacy:

☐ Yes ☐ No

I certify that this information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

TEXAS BREAST SPECIALISTS

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PI

Name: _____ Date of Birth: _____

Please state in your own words the reason for your visit:

_____

_____

_____

Breast / Gynecological History:

Last menstrual period: _____ Age of first period: _____

Number of Pregnancies: _____ Number of births: _____

Any miscarriages / abortions: _____ Age of first delivery: _____

Have you ever:

Breastfed: ☐ Yes ☐ No For how long: _____

Used Oral Contraceptives: ☐ Yes ☐ No For how long: _____

Used Hormone Replacement Therapy: ☐ Yes ☐ No For how long: _____

Had Chest Wall Radiation Therapy: ☐ Yes ☐ No For how long: _____

Family History:

Please list **any** relatives and age of diagnosis with the following:

Breast Cancer:

_____

_____

_____

Ovarian Cancer:

_____

_____

_____

Other Cancers:

_____

_____

_____

Physicians:

Referring: _____ OB/Gyn: _____

Primary Care: _____ Others: _____

TEXAS BREAST SPECIALISTS

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PI

Prescription History Consent

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I attend or receive services from Texas Oncology unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form, or it has been read to me.

Date: _____

Print Name (Patient): _____ DOB: _____

Signature of Patient / Legally Authorized Representative:

_____

Relationship to Patient (if patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader / Translator Signature: _____ Date: _____

_____

Notice of Privacy Practices

I acknowledge that the Texas Oncology Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge that I have received a paper copy of the Texas Oncology Notice of Privacy Practices.

_____ **(Patient's Initials)**

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

PI

Photographic Consent

Dr. King and Dr. Sprunt routinely photograph each of their patients in order to follow their exam and results over time. all photos are digital and stored securely, and are only used for medical records, treatment planning, documenting the course of treatment, and education. My signature below indicates that I hereby consent to my photographs being taken and used in this manner.

_____

Printed Name

_____

Signature (Patient or Legal Guardian

_____

Date:

Heather King, MD

Breast Surgery – Oncology and Oncoplasty

Texas Breast Specialists – Texas Oncology

Austin, TX

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Breast Specialists.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Breast Specialists Use Only:
Date acknowledgement received: _____

~ OR ~

Reason acknowledgement was not obtained: _____

_____

_____

Internal Use Only	Name	
	DOB	
	MRN	
	Text Opt In: ☐ Yes ☐ No	PHI/ROI Update: ☐ Yes ☐ No

TEXAS ONCOLOGY

Patient Billing

"What our patients and families need to know."

Texas Oncology provides both quality medical and financial care to our patients. Patient confidentiality is maintained while receiving appropriate payment for the medical care provided. The following is a detailed summary of our policies and procedures regarding patient billing.

1. Patients will receive a cost estimate from a Business Office representative upon request if the insurance will not fully cover all services and/or the patient is underinsured or declared indigent.
2. Patients must pay co-pays at the time of service.
3. Primary, secondary, and tertiary insurance claims for services rendered will be filed by the Business Office.
4. After a payment is made by the insurance company, the Business Office will reconcile the explanation of payment. The patient will be billed for the unpaid amount unless a contract with an insurance carrier prohibits it.
5. Any claim denied due to patient ineligibility, benefit limits, or services not covered will be billed directly to the patient unless a contract with the insurance carrier prohibits it.
6. Patients should promptly notify the Business Office of any changes in insurance coverage, billing address, legal name, or referring physician.
7. Patients may request an alternative billing address.
8. Patient billing statements will be mailed out every 30 days with a return envelope.
9. Patients receiving treatment should inform the Business Office when admitted to a Skilled Nursing Facility.
10. A patient may request a patient statement of billed charges and payments at any time.
11. Patients may pay balances online using the Online Bill Pay portal at www.texasoncology.com.
12. All payments received will be electronically processed.
13. Texas Oncology does not charge interest for amounts past due; however, we reserve the right to submit any unpaid accounts over 120 days to an outside collection agency.
14. Any patient may receive text notifications, regarding their outstanding balance, to their mobile device. A patient may request to opt in or out of text notifications at any time by contacting their physician's Business Office. Message and data rates may apply.
15. Any patient balance over 45 days will receive a letter and/or phone call to either collect or to arrange a payment plan.
16. If a patient receives direct payment from an insurance company or a patient advocacy program, specifically indicated as payment for services rendered, Texas Oncology reserves the right to submit the balance due to an outside collection agency.
17. Any billing questions regarding oral medications are addressed by the pharmacist/pharmacy staff.
18. All Medicare beneficiaries are provided a copy of the Medicare Oncology Care Model Beneficiary Notification.
19. A patient may provide consent to release financial information in order to have others act on their behalf. Consent may be updated at any time by contacting their physician's Business Office.

Questions or complaints should be directed to the Texas Oncology Business Office at (____) ____-_____.

Patient Initials _____

Internal Use Only		
	Name	
	DOB	
	MRN	
	Text Opt In: ☐ Yes ☐ No	PHI/ROI Update: ☐ Yes ☐ No

TEXAS ONCOLOGY

Financial Release of Information

As the patient, you are in control of the financial records pertaining to your medical care. We will not disclose financial information without your presence or advanced consent unless there is evidence of legal authority for another individual to act on your behalf. If you would like to provide advanced consent to disclose and discuss financial matters of your account with other individuals, please indicate in the fields below:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please note that staff will ask for key identifying elements that assist in establishing the proper individual. This may include the patient's legal name, date of birth, gender, address, telephone number, guarantor, subscriber, or other unique personal identifiers. To revoke consent at any time for any individual indicated above please contact our Business Office directly. You may be required to complete another Release of Financial Information form.

Texas Oncology collects Social Security Numbers (SSNs) for claim and reimbursement practices. Your privacy and confidentiality are important. Your personal information is maintained securely and accessed only to complete essential business functions. Please indicate your government issued Social Security Number in the field below:

_____ - _____ - _____

Please acknowledge the following statements:

☐ I consent to the individuals listed above to have access to my financial record and act on my behalf.

☐ I consent to receive text notifications of my financial statements at _____ - _____ - _____

☐ I have reviewed a copy of the Patient Billing form (page 1) and accept the terms.

Please sign and provide date and time stamps below:

_____ _____
Patient Signature Date/Time

_____ _____
Responsible Party Signature Date/Time

TEXAS ONCOLOGY

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

1. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier and/or benefits provider at the time of service. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier and/or benefits provider to release information regarding my coverage to Texas Oncology P.A.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. This assignment covers all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier and/or benefits provider prohibits an assignment of benefits, I hereby instruct and direct my insurance carrier and/or benefits provider to make benefits checks payable to me and mail it to the attention of my name "in care of" to the following address:

   c/o Texas Oncology, P.A.
   12221 Merit Dr., Ste. 500
   Dallas, TX 75251
4. I authorize Texas Oncology to pursue administrative appeals and file suit for payment and all other causes of action, including but not limited to ERISA claims, and to pursue legal action against me if I fail to endorse any payments I receive to Texas Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Name (Please Print): _____

Patient Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Oncology Use Only

Date Acknowledgement Received: _____ MRN: _____