Patient Name: ________________________________ **MRN:** _________________

BREAST PATIENT HISTORY QUESTIONNAIRE

Patient Name: ____ Today's Date: _____________________

Referring Physician: ____

Primary Care Physician: ____________________________________

For MD/Nursing ONLY:

DOB:

AGE:

HEIGHT:

WEIGHT:

BP:

PULSE:

RESP:

BREAST HISTORY

Briefly describe your current breast/chest problem (including location in right and/or left breast or chest, time of onset of problem and duration of problems): _______________________________

____

____

____

BREAST IMAGING

Date and location of most recent:

Mammogram: ____

Ultrasound: ____

MRI: ____

Have you had prior breast problems or biopsies? ❑YES ❑NO If yes, please provide date, location, and result of biopsy: ____

____

Have you received prior surgery, chemotherapy, hormonal (endocrine) or radiation therapy for breast cancer? ❑YES ❑NO If yes, please provide date and location of treatment:

Surgery: ____

Radiation: ____

Chemotherapy: ____

Hormonal (Endocrine): ____

Is there any history of breast and/or ovarian cancer in your family? ❑YES ❑NO If yes, please list:

Relationship	Age at Diagnosis	Type of Cancer

Have you or any member of your family undergone genetic testing for cancer? ❑YES ❑NO

If yes, what were the results of the testing? ____

____

Patient Name: ________________________________ **MRN:** _________________

BREAST PATIENT HISTORY QUESTIONNAIRE

PAST MEDICAL HISTORY:

___________________________ ____________________________ __________________________
___________________________ ____________________________ __________________________
___________________________ ____________________________ __________________________
___________________________ ____________________________ __________________________

Past Surgery: ❑YES ❑NO If yes, please list here any past surgeries with approximate age at which performed (include minor surgeries such as tonsillectomy, tumors, etc.)

____ ____
____ ____
____ ____

Age at first period: _________________________ Date of last menstrual period: __________________

Age at last period (menopause): _____________ Date of last PAP: ______________________________

Number of pregnancies: ___________________ Number of living births: _______________________

Age at first live birth: _______________________ Did you breastfeed? ___________________________

Current bra size: __________________________

MEDICATIONS

Do you now or have you taken hormones, estrogen therapy or birth control pills? ❑Yes ❑No
Birth Control Y / N Type: __________________________ How long? ____________________________
Estrogen Therapy Y / N Name/type: ____________________________ How long? _________________
Hormone Replacement Therapy Y / N Name/type: ________________________ How long? ___________

MEDICATIONS: Please list all medications and dosage, including over the counter medications/herbal supplements and length of time taking the drug:

Name of medication:	Dosage:	Length of time:

Drug Allergies: ❑Yes ❑No
Please list each medication separately and the side effects you experience:

Name: **Side Effect:**

____ _______________________________
____ _______________________________
____ _______________________________

MD/Nursing Notes

Patient Name: ________________________________ MRN: _________________

BREAST PATIENT HISTORY QUESTIONNAIRE

MD/Nursing Notes:

FAMILY HISTORY: Is there a history of cancer or other disease in your family? ❑Yes ❑No
If yes, please list:

Relationship and age diagnosed:	**Type of Cancer or Disease:**
____	______________________________
____	______________________________
____	______________________________

SOCIAL HISTORY: Are you currently: ❑Employed ❑Retired ❑Unemployed ❑Disabled

Occupation: (current or former) ____

Are you: ❑married ❑single ❑widow(er)

Live with: ❑spouse ❑significant other ❑friend ❑children ❑other

HABITS:

Do you now or have you ever smoked? ❑Yes ❑No If yes, how long have/did you smoke?

# of years: __________ Packs per day? ________ If you quit, when? ____________(# of years ago)

Do you drink alcohol (wine, beer or liquor)? ❑Yes ❑No If yes, how much per week? _____________

Do you have a history of drug or alcohol abuse (including prescription drugs)? ❑Yes ❑No

Do you exercise? ❑Yes ❑No

Type / frequency of exercise each week: ____

____

BONE HEALTH

Date & location of last bone densitometry (DEXA): ____

Result: ❑ Normal ❑ Osteopenia ❑ Osteoporosis

Do you now or have you ever taken medication for bone health? ❑Yes ❑No If yes, what type and how long did you take it? ____

Do you take a daily supplement of Calcium? ❑Yes ❑No and/or Vitamin D? ❑Yes ❑No

Activity Level (check which applies)

❑Fully active
❑Restricted in physically strenuous activity; ambulatory and able to do light work
❑Walking without aid, capable of all self care; up and about more than 50% of waking hours
❑Capable of only limited self care; confined to bed or chair more than 50% of waking hours
❑Completely disabled; cannot do any self care; totally confined to bed or chair

Patient Name: ______________________________ MRN: ________________

BREAST PATIENT HISTORY QUESTIONNAIRE

Please circle if you have any of the following documents: **Living Will** **Advance Directives**
*If you have one of these documents, please provide **Power of Attorney for Medical Care**
a copy for our office.

Do you want information on any of the documents listed above? ❑Yes ❑No

Circle all that apply:

General	Weight gain / Weight loss How much? ___________ Over how long? ________	Fever How high? ______ Night sweats Fatigue	Chills Hot flashes
Eyes	Vision changes / Blurry vision	Blind spots Eye pain	Tearing
Ears/Nose Mouth/Throat	Bleeding gums Dental problems Dentures	Dizziness/Lightheadedness Mouth sores Nasal congestion	Nose bleeding Sore throat
Cardiovascular	Chest pain Fainting Heart murmur	Irregular heart beat Heart palpitations Blood clots Swelling/Edema	Phlebitis Varicose veins Shortness of breath with / without exertion
Respiratory	Cough Coughing up blood	Pain with deep breathing Respiratory infection	Wheezing
Gastrointestinal	Abdominal pain Black, tarry stool Blood in stool Constipation / Diarrhea Poor appetite	Difficulty swallowing Gas/Flatulence Heartburn/Indigestion Hemorrhoids Nausea/Vomiting	Vomiting blood Yellow skin Recent changes in bowel habits?
Genitourinary	Blood in urine Frequency Lack of urine	Painful urination Stones Urgency	Urinary incontinence Urinary infection
Musculoskeletal	Joint pain Limitation of motion	Muscle cramps Muscle weakness	Muscle pain Neck pain/tenderness/ stiffness
Skin	Changes in moles Easy bruising	Itching Nail changes	Pigmentation Rash
Breast	Breast lumps Breast pain	Breast swelling Breast tenderness	Nipple discharge
Neurologic	Gait changes Headaches Weakness	Difficulty with speech Difficulty with memory Vision changes	Poor coordination Numbness
Psychiatric	Anxiety Depression	Emotional problems Hallucinations	Nervousness Trouble sleeping
Endocrine	Anemia Diabetes	Heat / Cold intolerance Increased water intake	
Heme/Lymph	Easy bruising / bleeding	Enlarged lymph nodes	
Other			

MD/Nursing Notes:

Patient Name: ________________________________ MRN: _________________

TEXAS BREAST SPECIALISTS

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Electronic Mail Authorization Form

Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record; we will not activate your personal account unless you authorize us to do so.
Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

TERMS

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

____ ____

Patient Name (First Name, Middle Initial, Last Name) Email Address of Patient/Authorized User

____ ____

Date of Birth of Patient Physician's Name

Authorized User is: ❑Patient ❑Patient's Designee

____

Patient's Designee's Name (Printed)

____

Patient's Designee's Signature

____ ____

Patient's Signature Date Signature of Practice Staff Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e. the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Patient Name: ________________________________ **MRN:** _________________

PATIENT CONFIDENTIALITY AGREEMENT QUESTIONNAIRE

Please list the people that may obtain information about your medical history and diagnosis:

____

____

Emergency Contact: ____

Relation to Patient: ____

Phone Number: ____

Any other address we may send billing information to other than your home:

____

____

Please list the telephone numbers where you would like to receive phone calls concerning your appointments, labs, x-ray results, or other health information other than your home number: *(Please be aware that a cell phone is not a secure or private line)*

____

Can confidential messages be left on your telephone or answering machine/voicemail? ❑Yes ❑No

Patient Name: ____

Patient Signature: ____

Representative: ____

Relation to Patient: ____

Date: ____

Patient Name: ________________________________ **MRN:** _________________

Consent/Authorization for Release of Information

1. **I herby authorize:**
2. Name: ____ Address: _______________________________________
3. City: ____ State: ______________________ Zip: ______________
4. Phone: ____ Fax: ____

To release the following information from the health record(s) of:

Patient Name: ____

Date of Birth: ______________________________________ Phone Number: ___________________________________

Covering the periods of treatment: From: _____________________________ To: ______________________________

5. **Information to be released:**

❑ Progress Notes
❑ Radiology
❑ Lab
❑ Billing records
❑ X-ray films
❑ Complete Medical Record (includes information regarding insurance, demographics, referral documents and records.

Mail Copies: _________________
Patient Pick-up: ______________
Faxed: _____________________
Initials: ____________________

6. **Information to be released to:**

Name: ____ Address: _______________________________________

City: ____ State: ______________________ Zip: ______________

Phone: ____ Fax: ____

Purpose of disclosure:

❑ Treatment ❑ Payment ❑ Health Care Operations ❑ Other: _____________________________________

7. **I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information as acted in reliance upon this authorization.**

8. **THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.**

9. **The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.**

10. **I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.**

Signature: ____ Date: ____________________________
Patient or Legal Representative

Witness: ____ Relationship: ______________________________________

Patient Name: ________________________________ **MRN:** _________________

INSURANCE

Due to new Medicare and insurance billing requirements, all paperwork must have the patient's name exactly as it appears on the insurance card.

Please complete the following paperwork EXACTLY the way the name appears on the insurance card.

Print Name: ____

Signature: ____ Date: ___________________________

NOTICE TO PATIENTS REGARDING COPAYMENTS

If your insurance requires a co-pay for your services, we have a responsibility to collect this from you. If we don't collect a required copayment, we are in violation of our contract with the insurance company and could lose the ability to provide services for that carrier. We make every effort to be correct in asking for copayments. If you feel that we have asked in error, please call it to our attention and we will research your coverage to be sure a copayment is required.

Besides doctor's visits, there are other situations that may require a copayment.

Some examples: Port/line flushes, lab draws, dressing changes
Nurse visit with doctor interaction
Chemotherapy/radiation

Print Name: ____

Signature: ____ Date: ___________________________

Patient Name: ________________________________ **MRN:** _________________

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.

Print: ____ DOB: __________________________

Signature: ____ Date: __________________________
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 sign below:

Signature: ____ Date: __________________________
Reader or Translator

Patient Name: ________________________________ **MRN:** _________________

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 Financial Counselor 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 an 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 also request an alternative billing address.
8. Patient billing statements will be mailed out every 30 days with a return envelope.
9. Patients under current treatment should inform the Business Office when admitted to a Skilled Nursing Facility.
10. A patient may request a patient ledger of billed charges and payments at any time.
11. Patients may pay balances online using www.texasoncology.com
12. Checks received will be electronically processed.
13. Texas Oncology does not charge interest for amounts past due; however, the physician reserves the right to submit any unpaid accounts over 120 days to an outside collection agency.
14. Any patient balance over 60 days will receive a letter and/or phone call to either collect or to arrange a payment plan.
15. If a patient receives direct payment from an insurance company or a patient advocacy program, specifically indicated as payment for services rendered, the physician reserves the right to submit the balance due to an outside collections agency.

Questions or complaints should be directed to your physician's Business Office.

Print: ____ DOB: __________________________

Signature: ____ Date: __________________________

Patient/Legally Authorized Representative

Relationship to Patient (if patient not signing: ____

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ASSIGNMENT OF BENEFITS/FINANICAL RESPONSIBILITIES

Patient Name: ____ Date: ___________________
Last First M.I.

Home Address: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

DOB: ___/___/______ Age: ________ ❑ M ❑ F ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other
Check Marital Status

SSN: ______________ Race: ______________ Ethnicity: Hispanic/Latino ❑ Y ❑ N Preferred Language: ___________

Home Phone: ____________________ Cell Phone: _______________________ Email:_________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology® is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. 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 am aware it also outlines my rights with regard to my health information. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

Please sign below to acknowledge that you have received our Notice of Privacy Practices.

Print: ____ DOB: __________________________

Signature: ____ Date: __________________________
Patient/Legally Authorized Representative

Relationship to Patient (if patient not signing): ____

Patient Name: ________________________________ **MRN: _________________**

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us: In this Notice, we use terms like "we," "us," "our," or "Practice" to refer to Texas Oncology, its physicians, employees, staff **a**nd other personnel. All of the sites and locations of Texas Oncology follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of This Notice: This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities: We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information:
The following categories describe examples of the way we use and disclose health information without your written authorization:
For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another health care provider to be sure they have all the information necessary to diagnose and treat you.
For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company