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.

Please circle below:

Preferred Language: English Spanish Other:_____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Preferred Method of Contact: Home Phone Cell Phone Work Phone

Email Mail Home Address

Additional Phone number: _____ Home/Cell/Work

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

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Patient Name: _____ Date of Birth: _____

Today's Date: _____ MRN#: _____

Any new breast issues?

_____

_____

Any changes to your overall health?

_____

_____

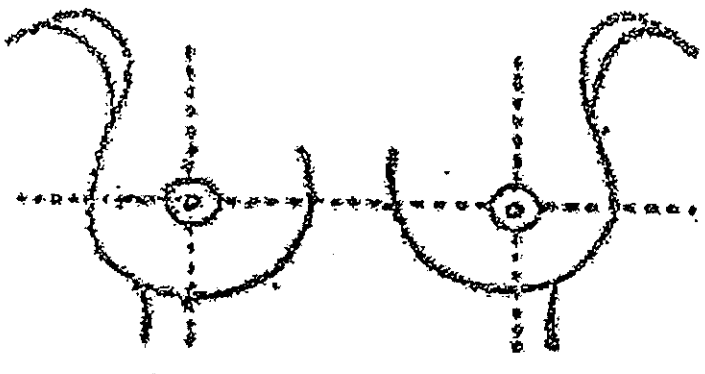
Date of most recent mammogram? _____

Any other breast imaging? _____

Referring Physician: _____

Primary Care Physician: _____

_____PLEASE DO NOT WRITE BELOW_____



Impression / Plan:

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Heather M. King, MD *Julie Sprunt, MD*

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please indicate any symptoms you are currently 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:

_____

_____

_____

_____

_____

_____

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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:

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

☐ Yes ☐ No

Name _____

Address / Cross Streets _____

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

Patient Signature: _____ Date: _____

TEXAS BREAST SPECIALISTS

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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 Total months: _____

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 ONCOLOGY

More breakthroughs. More victories.

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 payers 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)**

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Photographic Consent

Drs. King and Sprunt routinely photograph 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 consent to my photographs being taken and used in this manner.

_____

Printed Name

_____

Signature (Patient or Legal Guardian)

_____

Date

Heather King, MD *Julie Sprunt, MD*

Breast Surgical Oncology and Oncoplasty

Texas Breast Specialists

TEXAS BREAST SPECIALISTS

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ESAS PATIENT EDUCATION TOOL

Patient Name: _____Date of Birth __/____/_____ Today's Date: _____

Your overall well-being is important to us. Below are some concerns common to many patients. Please take a few moments to complete the following so that we can understand your concerns and support you.

How you are feeling and your symptoms that you are experiencing is very important and helpful to us!

Your healthcare team cares for your overall well-being and wants to know how you are feeling each time you come into a Texas Oncology center. This will assist us in providing you with the best possible care.

Only you can tell us about your symptoms. By letting us know how you are feeling at each visit, we are better able to help you.

ESAS: Edmonton Symptom Assessment Scale

Please **CIRCLE** the number that best describes how you feel **TODAY:**

No Tiredness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Depression	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
No Drowsiness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
Best Wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ (other problem)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

What happens after I complete the ESAS?

ESAS answers are entered into your medical chart so they are available to your health care team. All ESAS responses are strictly confidential. Because your symptom scores are kept as part of your medical record, your health care team is able to trend your symptoms over time for better planning of your care. ESAS results will be used as one part of your overall medical review. When you identify a symptom or concern, your health care team will do a further assessment.

Be sure that all of your concerns are discussed at your appointment with your health care team, including those that are not part of the ESAS questions.

Thank you for allowing us to be a part of your care.

For office use only

IKM#_____ Physician's Name_____

TEXAS BREAST SPECIALISTS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRICVACY 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: _____
_____
_____

TEXAS BREAST SPECIALISTS

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User 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 indentifying 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 your 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 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 Medical Record Number

Patient's Signature

Date

Signature of Practice Staff
(confirming user's identity and authority)

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 & agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff Use Only:	MRN_____
Email in P{MS or iKM_____	iKM Consent_____

TEXAS ONCOLOGY

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 at (xxx) xxx-xxxx.

Patients Name _____ Signature _____ Date _____