*Noman Rafique, M.D.*
*Nagaprasad Nagajothi, M.D.*
*Scott McGee, M.D.*

7337 Caritas Cir. NW , Suite 150
Massillon, OH 44646
Phone: **330-478-0001** FAX: **330-837-2646**

**If you have NOT spoken to the office by phone:**
**PLEASE CALL US TO CONFIRM YOUR APPOINTMENT**
**Thanks,**
**330-478-0001**

Date:____________________

Dear Patient:

Today, I scheduled an appointment for your consultation with **Dr. ____________**

At our office at **7337 Caritas Cir. NW, Suite 150, Massillon, OH 44646.**

**Date: ___________________________**

**Time: __________________________**
**(Please arrive at least 15 minutes prior to scheduled appointment)**

Please complete the attached forms prior to your appointment. If there is anything you are not sure of, we will be happy to help you when you get here.

When you arrive at the office, you will report to the front desk where you will be asked to sign a medical release and HIPAA Notice of Privacy Practice. Don't forget to bring your Insurance & Prescription Cards– these will be copied for your chart.

Shortly after you arrive, a member of our laboratory staff will draw some blood (*no need to fast*) then take you to an examination room where you will meet the doctor who will then review all the your records, interview and examine you. If you want to bring a spouse, family member, or significant other to assist you in understanding this discussion, we have no objection.

Also – please bring any medication bottles that you are currently taking ( or a complete list with dosages and times) to your first appointment so that we can accurately record your medication and proper dosage in your chart.

We look forward to welcoming you to our practice.

## Limited Patient Authorization for Disclosure of Protected Health Information

**Form 7.31**

Please print all information. Form must be signed and dated.

**Patient Name:** ______________________________________________

**SSN (last four digits):** ____________________ **Date of Birth:** ____________________

**Entity Requested to Release Information:** ______________________________________________

**Purpose of request (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

**Who will be authorized to receive information** (the individual/entity who is to receive your PHI):

Tricounty Hematology and Oncology Associates, Inc.
7337 Caritas Circle NW, Massillon, OH 44646
Phone: (330) 478-0001 Fax: (330) 837-2646

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: ____________________

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): ______________________________

- ∞ This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: ____________________
- ∞ You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- ∞ The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- ∞ We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

______________________________________________ ____________________

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

## Patient Authorization for Personal Representative

**Form 7.30**

Please print all information, then sign and date form at bottom.

**Name of Practice:** Tricounty Hematology and Oncology Associates, Inc.

**Patient Name:** ______________________________________________

**Social Security Number:** ____________________ **Date of Birth:** ____________

**Purpose of request:** I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

______________________________________________

Name of Personal Representative Phone

______________________________________________

Address

______________________________________________

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

______________________________________________

______________________________________________

______________________________________________

Attn: Privacy Manager.

**Redisclosure**: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

______________________________________________ ____________

patient signature date

Copies of signed authorizations are available upon request.

NAME: ______________________ AGE:______ DATE:______________

**PAST MEDICAL HISTORY:**

______________________
______________________
______________________
______________________
______________________
______________________
______________________

**PAST SURGICAL HISTORY:**

______________________
______________________
______________________
______________________
______________________
______________________
______________________

**CURRENT MEDICATIONS:**

______________________
______________________
______________________
______________________
______________________
______________________
______________________
______________________
______________________
______________________

**DRUG ALLERGIES/REACTIONS:**

______________________
______________________
______________________
______________________
______________________
______________________
______________________

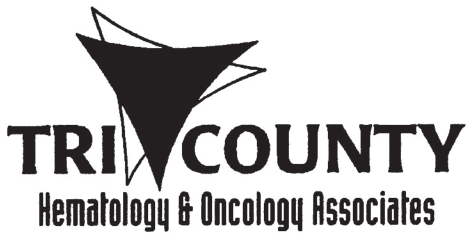
**MENSTRUAL HISTORY:**

Age of menarche:_____ Age at menopause:_____ Last menstrual period:__________

Age at First Childbirth:_____ Number of Children:_____

Oral estrogens or patch (#years):_____ Birth control pills (#years):_____

Hysterectomy?_____ Ovaries removed? ________________




# FINANCIAL POLICY

We realize that the cost of health care is a concern for our patients. We offer the following information to help you understand our financial policy and aid you in planning for payment.

- Our office accepts cash, check, debit or Visa/Mastercard
- All co-payments, as required by your insurance contract, are due at the time of service. Failure to pay your co-payment will result in a $5.00 statement charge.
- With the proper information, we will prepare and file your insurance claims as a courtesy to you. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We CANNOT guarantee payment of your claims. Reduction or Rejection of your claim by your insurance company does not relieve your financial obligation to our office.
- We ask that you keep us informed of any changes to your insurance. Patients are expected to bring their current insurance cards to each visit.
- Patients who are not covered by a healthcare plan are asked to consult with the billing office at the time of their first visit to discuss options available to them.
- Our billing staff is available to answer any questions regarding your account. Although we do our best to ensure coverage of your services, it is important for you to be aware of your coverage details.
- We send patient statements on a monthly basis. If you are responsible for a balance, we ask that payment be made within 30 days of the statement. If you need to make payment arrangements, please contact the billing office.

____________________________ ________________
Patient Signature Date

**Norman Rafique, M.D. | Nagaprasad Nagajothi, M.D. |**
**Scott McGee, M.D. |**

Patient ID: | Patient Name: ____________ ____________ ____________ ____
First Middle Last Sex

Address: ______________________ ____________ ____ ______
Street City State Zip

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Email: ____________ Marital Status: ____________

Date of Birth: ____________ Age: ____________ SSN: ____________

City/State of Birth: ____________ Race: ____________ Ethnicity: ____________

Language: ____________ Currently Employed ☐ Retired ☐ Never Worked ☐

Current or Retired from Employer: ____________ Occupation: ____________

Spouse Name: ____________ Spouse Cell: ____________ Spouse DOB: ____________

Emergency Contact: Name: ____________ Relationship: ____________

Phone: ____________

Doctor: ____________ Preferred Pharmacy: ____________

Referring MD: ____________ Ref MD Ph: ____________ Ref MD Fax: ____________

Living Will: Yes ☐ No ☐ Durable Power of Attorney: Yes ☐ No ☐ Unknown ☐ DNR: Yes ☐ No ☐ Unknown ☐

Preferred Hospital (circle one): Aultman Mercy Affinity Union Twin City Alliance

Primary Ins: ____________ ID: ____________ Group #: ____________

Policy Holder: ____________ Birthdate: ____________

Relationship: ____________

Secondary Ins: ____________ ID: ____________ Group #: ____________

Policy Holder: ____________ Birthdate: ____________

Relationship: ____________

## *ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES*

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to Tri-County Hematology & Oncology Assoc. Inc. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I understand that I am responsible for any amount not covered by insurance

Signature: ____________ Date: ____________ Employee Initials: ____________

## SOCIAL HISTORY:

I live with ____________________________________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation ________________________________ Retired?______ When?______

Smoker?_____ ____packs/day for _____years. Quit in ____________

Any alcohol intake? _____ Number of drinks per week______ Quit in __________

Any IV drug? __________ Last date of such use ____________________

## FAMILY HISTORY (diseases in the family)

MOTHER ________________________ FATHER ________________________

Brothers ________________________ Sisters ________________________

________________________ ________________________

________________________ ________________________

Children ______________________________________________

Others ______________________________________________

## REVIEW OF SYMPTOMS (Circle any that apply)

**NEURO:** Headache Seizures Stroke/TIA Weakness Numbness Anxiety Depression

**HEENT:** Double Vision Blurry Vision Ringing in ears Hearing change Nosebleeds Gum bleeding
Sinus congestion Dental problems Pain or trouble swallowing Choking

**LUNGS:** Shortness of breath Wheezing Chest pain Cough-phlegm color___________ any blood?_____

**HEART:** Chest pain/angina Palpitations/Arrhythmia Dizziness Passing out
Shortness of breath? (with activity or lying down or at night) Swelling

**GI:** Nausea Vomiting Diarrhea Constipation Abdominal pain
Ulcers Blood in stool or dark stool Hemorrhoids Jaundice

**MUSCULOSKELETAL:** Arthritis Joint pains Bone pain Muscle aches

**GENITOURINARY:** Burning with urination Bloody urine Difficulty with stream
Get up at night? ___ Bladder/Kidney Infections Kidney stones Incontinence/Leaking

**GYNECOLOGIC:** Vaginal bleeding Vaginal discharge Dryness Yeast infections
Last PAP smear ________________

**SKIN:** Rashes Lesions Dryness Itching

**GENERAL:** Decreased appetite Weight Loss (# pounds ________)
Fever Night Sweats Chills Hot flashes Fatigue Weakness