CENTRAL GEORGIA CANCER CARE

Passion for innovation, compassion for your care.

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Welcome to Central Georgia Cancer Care. We specialize in treating patients with cancer and benign blood disorders.

Your appointment details are as follows:

Provider:_____ Appointment: _____ Arrival time:_____

Address:

○ Macon Office
Inside the Peyton Anderson Cancer Center
800 First Street, Suite 410
Macon, GA 31201
(478) 743-7068

○ Warner Robins Office
Inside the Houston Cancer Center
114 Sutherlin Drive, Suite C1
Warner Robins, GA 31088
(478) 287-6144

Since 1977, Central Georgia Cancer Care has pioneered effective treatments in Medical Oncology and Hematology. Our physicians are leaders in customizing patient care, often using an integrated plan of chemotherapy, immunotherapy and targeted therapy to optimize your health outcomes. We participate in several clinical trials, offering breakthrough treatment options to eligible patients. Our practice is one of 190 practices nationally selected to participate in Medicare's Oncology Care Model to establish best practices for the future. Central Georgia Cancer Care also has an exceptional team of Physician Assistants and Nurse Practitioners who work closely with our physicians to provide services that have been approved by the Georgia State Board of Medical Examiners.

Central Georgia Cancer Care participates with Medicare, Medicaid, and most commercial managed care plans. Patients are responsible for paying copays, deductibles, coinsurance, and account balances at the time of service unless prior arrangements have been made. If a financial hardship is anticipated, please call one of our Patient Account Representatives at 478-743-7068, option 6.

If you have questions before your appointment, please contact our Patient Navigators:
Macon Office (478) 743-7068, ext 249. Warner Robins (478) 287-6144, ext 370. We are happy to address your questions, coach you through what to expect, and help you make the most of your time with your doctor.

If you have children under the age of 12, please arrange for their care during your appointment. For the health and safety of our patients, children are not permitted beyond our waiting room and may not remain in our waiting room unattended.

Please complete the enclosed paperwork and bring it with you to your first appointment. Our physicians keep a full schedule and have reserved time for your first visit. If you are unable to keep your appointment, please call our office to reschedule. Our office hours are Monday through Friday, 8:30 a.m. to 5:00 p.m.

Sincerely,

Cile Lind
Practice Administrator

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New Patient Registration

Patient Information

Name _____ (Last) _____ (First) _____ (Middle) Is this your legal name? ○ Yes ○ No

Birth Date _____ Place of Birth _____ Age _____

Social Security # _____ Sex ○ Male ○ Female Marital Status ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Street Address/P.O. Box _____

_____ (City) _____ (State) _____ (Zip code)

Email Address _____

Home # (_____) _____ Cell # (_____) _____ Work# (_____) _____

Ethnicity _____ Religion _____ Primary Language _____

Employer _____ Occupation _____

Employer Phone # (_____) _____ Employment Status ○ Active ○ Retired _____ (Retirement Date)

Employer Address _____

_____ (City) _____ (State) _____ (Zip code)

Insurance Information

Primary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Employer Address _____

Occupation _____ Employer Phone _____

Patient's Relationship to Subscriber: ○ Self ○ Spouse ○ Child ○ Other _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Employer Address _____

Occupation _____ Employer Phone _____

Patient's Relationship to Subscriber: ○ Self ○ Spouse ○ Child ○ Other _____

Signature

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize the release of any medical or other information necessary to process this claim. I authorize my insurance claims to be paid directly to the clinic. I also give permission to the provider to file an appeal on any insurance claim if necessary.

_____ (Signature) _____ (Relationship to Patient) _____ (Date)

Central Georgia Cancer Care New Patient History

Name: _____ **Date of Birth :**_____

By what name do you prefer to be called: _____ Age ____

Reason for referral or visit to our practice: _____

- Who referred you to our office? _____
- Who is your family or primary care doctor? _____
- Do you see any other specialists? If so, who? _____

Social History

How long is your commute to our office? _____

Occupation/Job: _____ Are you currently working? **Yes or No**

Marital Status: _____ Name & ages of children: _____

Do you use tobacco? **Yes or No If yes how much? _____ When did you start? _____**

If no, did you ever use tobacco products? Yes or no When did you stop? _____

Do you use alcohol products? **Yes or no If yes: how much? _____ How often? _____**

Past Medical History

Do you have or have you ever had: (check box if yes)

☐ Heart Disease	☐ Congestive Heart Failure	☐ Lung Disease (Emphysema COPD) _____
☐ Diabetes	☐ Thyroid Problems	☐ Stomach Problems (Ulcer, Acid Reflux)_____
☐ High Blood Pressure	☐ Frequent Bladder Infections	☐ Bowel Problems _____
☐ Stoke or mini-stroke	☐ Kidney Failure or dialysis	☐ Hepatitis or cirrhosis: _____
☐ Epilepsy or seizures	☐ Enlarged Prostate	☐ Skin condition or rash _____
☐ Anemia	☐ Bleeding or Clotting Disorder	☐ Neurological Condition –(Parkinson's, etc._____
☐ Anxiety	☐ Blood Clot in Leg	☐ Eye Problems (Glaucoma, etc.)_____
☐ Endometriosis	☐ Blood Clot in Lung	☐ Previous Cancer_____

- Previous surgeries: _____
- Hospitalizations in last 10 years: _____
- Is there anything more you think we should know about you or your history?

_____

Check for Yes to the following questions:

- ☐ Do you spend more than half your day in bed or recliner?
- ☐ Do you require assistance with bathing, meal preparation, etc.?
- ☐ Do you take the flu shot every year? If so, when was your last flu shot? _____
- ☐ Have you ever had a colonoscopy? If so, when _____
- ☐ Have you had an echocardiogram before? If so, when _____
- ☐ Have you had a bone density test? If so, when? _____
- ☐ Do you have pain? If so, who manages your pain? Dr. _____
- ☐ For women only :
  - When was your last mammogram? _____
  - When was your last period? _____
  - Do you have hot flashes, vaginal dryness or menopausal symptoms? _____ When did they start? _____
  - Have you had a hysterectomy? _____ Do you still have your ovaries? _____
  - Do you take hormone replacement therapy? _____

Family History: Any history of the following diseases in your family? If yes, what is the relationship of the person to you?

- ☐ **Heart disease** _____
- ☐ **High blood pressure** _____
- ☐ **Cancer** _____
- ☐ **Genetic or chromosomal abnormalities** _____

Allergies:

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Food allergies: _____

Are you allergic to iodine, seafood or shellfish? _____

Current Medications: Please fill out this form to include any medicines you are currently taking. Remember to include any over the counter drugs and herbal products that you may take on a regular basis:

Drug Example: Lipitor	Strength 40mg	Directions one at bedtime	Start Date April, 2005	Prescribing Doctor Dr. John Jones

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date _____

Reviewed by Physician _____ Date _____

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E-Prescribing Information and Patient Consent

What is E-Prescribing and Why Does Central Georgia Cancer Care E-Prescribe?

E-Prescriptions, or Electronic Prescriptions, are computer generated prescriptions created by your provider and sent directly to your pharmacy. Central Georgia Cancer Care participates in E-Prescribing because we care about your health and wellbeing and E-Prescribing has multiple safety benefits.

How does E-Prescribing work?

Instead of writing out your prescription on a piece of paper, your doctor enters it directly into the computer. Your prescription travels from your doctor's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure and closed network, so your prescription information is not sent over the open internet or as email. Your E-Prescription arrives at the pharmacist's computer faster and may help you to save time. The E-Prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept E-Prescriptions, your provider can print your prescriptions for you. **Please be aware that not all prescriptions may be legally E-Prescribed, such as controlled substances. These will have to be mailed or picked up in person.**

Privacy

The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purposes of providing you with clinical care. E-prescriptions meet this requirement.

Patient Consent for E-Prescribing

I agree that Central Georgia Cancer Care may E-Prescribe my prescriptions and may request and use my prescription medication history from other providers or third party pharmacy benefit payors for treatment purposes.

Pharmacy Name _____ **Pharmacy Phone Number** _____

_____ ___/___/_____ _____

Patient Name (Print) Date of Birth Account Number

_____ _____

Patient Signature Date

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Acknowledgement of Receipt of Notices of Privacy Practices & Consent for Disclosure of Health Information

Name _____ SSN_____ DOB_____

CGCC has permission to disclose my health information to the people listed below.
Please list at least two people who we can contact if we are unable to reach you.
**You do not need to list your physicians on this form, we will send them the appropriate information.*

Primary Contact?

- ◉ Name_____Relationship_____Phone # _____
- ○ Name_____Relationship_____Phone # _____
- ○ Name_____Relationship_____Phone # _____
- ○ Name_____Relationship_____Phone # _____

By signing this form, you grant Central Georgia Cancer Care, PC consent to disclose your protected health care information to the individuals listed above. Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it as it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were taken in reliance upon this Consent. You are entitled to a copy of this Consent Form after you have signed. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

_____
Patient Name

_____
Date of Birth

_____
Patient Signature or Legal Representative

_____
Date

_____
Relationship to Patient

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Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of our Privacy Policy is available at our front desk and on our website at centralgacancercare.com. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

For Office Use Only:

Our practice made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please provide specific details)

_____

_____

_____ _____ _____

Employee Signature Print Employee Name Date

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Financial Responsibility and Assignment of Benefits

To provide timely and accurate payment to Central Georgia Cancer Care, PC for services rendered:

- I certify the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I hereby give lifetime authorization for payment of insurance benefits be made directly to Central Georgia Cancer Care, PC for services rendered.
- I request that payment of authorized benefits be made on my behalf to Central Georgia Cancer Care, PC for any/all services furnished to the patient listed below by the physician and healthcare providers for Central Georgia Cancer Care, PC.
- I authorize Central Georgia Cancer Care, PC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to their services and care provided.
- If my health insurance plan will not direct payment to Central Georgia Cancer Care, PC, I agree to forward to Central Georgia Cancer Care, PC all health insurance payments which I receive for the services rendered by this practice and its health care providers.
- I authorize Central Georgia Cancer Care, PC to release to my Health Insurance Plan my private healthcare information as needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed below which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I will pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. (co-pays, deductibles, etc)
- That this financial form with assignment of benefits applies and extends to subsequent visits, appointments and treatments rendered by Central Georgia Cancer Care, PC.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction and that I agree with each statement above.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature or Person Legally Responsible Date

_____

Relationship to Patient

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Consent to Obtain Medical Records

I hereby authorize Central Georgia Cancer Care, P.C. to obtain any/all of my medical records from any physician, hospital, or medical institution.

Name: _____

SSN: _____

Date of birth: _____

Date signed: _____

Signature: _____

Permission to share my medical information from Central Georgia Cancer Care, PC with my healthcare providers through the Central Georgia Health Exchange

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, Central Georgia Cancer Care, PC would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). You may already have authorized the sharing of your Health Information into the *Health Exchange* by signing a permission form when visiting the office of another doctor who participates in Central Georgia Health Network (CGHN). Due to differences in various computer systems, this specific authorization is required by law to release your Health Information to the *Health Exchange*. If you already have given your permission, then we will update your *Health Exchange* record with your Health Information from Central Georgia Health System. **If you have NOT previously given permission, then the Health Information disclosed by Central Georgia Cancer Care, PC will NOT be used to update the Health Exchange, even if you check "Yes" below.**

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange* and this permission form.

☐ **Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record**

☐ **No, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time**

_____	_____	_____
Printed Name of Patient	*Patient Date of Birth*	*Printed Name of Representative*

_____	_____
Signature of Patient or Representative	*Date Signed*

AUTHORITY OF REPRESENTATIVE:
I, _____, *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):* _____
[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow Central Georgia Cancer Care, PC to disclose your Health Information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the Health Exchange electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your Health Information. The *Health Exchange* system will allow your providers access to your Health Information more quickly and accurately than with paper charts.

By signing this form, I authorize Central Georgia Cancer Care, PC to use and disclose my Health Information and to make such Information available through the Health Exchange to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the Health Exchange and of CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange MSC 98, 777 Hemlock Street, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.