LOW COUNTRY RADIATION
AMERICAN ONCOLOGY PARTNERS

Place Label Here

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship to Patient

_____ _____

Signature of Witness Date

_____

Printed Name of Witness

Patient Name: _____ **DOB:**_____

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age**: _____ ❑ **Male** ❑ **Female** **SS#**: _____

Primary Address: _____

City: _____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets:_____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____ Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

If yes, please bring a copy with you.

Patient Name: _____ **DOB:** _____

Medical History

Have you EVER had any of the following:

❑ Asthma
❑ Psychiatric Disorder/Illness
❑ Cancer
❑ Seizures or Epilepsy
❑ Diabetes
❑ Urinary/Kidney Disorder
❑ Neurological Disorder/Chronic Headaches
❑ Blood Pressure Disorder/Hypertension
❑ Stroke
❑ COPD
❑ Thyroid Disorder
❑ Heart Attack/Heart Disease/Atrial Fib
❑ Arthritis
❑ Pulmonary Embolism/DVT/Blood Clots
❑ Cholesterol Disorder/Hyperlipidemia
❑ Sleep Apnea
❑ Eye Disorder (i.e. Glaucoma)
❑ Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? ❑ Yes ❑ No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Allergies

Are you allergic to any medications or other substances? ❑ Yes ❑ No Please list allergies and reactions:

_____

_____

Patient Name: _____ **DOB:** _____

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? ❑ Yes ❑ No If yes, please use the back of this page to list all others.

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? ❑ Yes ❑ No

Date of last mammogram: _____ Was that mammogram normal? ❑ Yes ❑ No

Date of last colonoscopy: _____ Was that colonoscopy normal? ❑ Yes ❑ No

Obstetrics History

Are you currently pregnant? ❑ Yes ❑ No If yes, anticipated due date: _____

Attempting to conceive? ❑ Yes ❑ No # of Pregnancies:_____ # of Births:_____ # of Miscarriages: _____

Family Medical History

Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Social History

Do you currently smoke? ❑ Yes ❑ No If no, previously? ❑ Yes ❑ No

Years smoked:_____ Packs per day: _____ Do you use other tobacco products? ❑ Yes ❑ No

Consume Alcohol? ❑ Yes ❑ No If yes, drinks per week: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you suffer from domestic violence? ❑ Yes ❑ No Do you feel safe at home? ❑ Yes ❑ No

Patient Name: _____ **DOB:** _____

Review of Systems Please indicate ALL that you have experienced within the last 6-12 months.

General

❑ None ❑ Feeling Tired ❑ Fever ❑ Weight Gain
❑ Chills ❑ Weight Loss ❑ Feeling Poorly

Eyes

❑ None ❑ Dry Eyes ❑ Eye Pain ❑ Itchy Eyes
❑ Vision Changes ❑ Eyesight Problems

Ear/Nose/Throat

❑ None ❑ Earache ❑ Loss of Hearing ❑ Nose Bleeds
❑ Sinus Problems ❑ Sore Throat ❑ Hoarseness

Heart

❑ None ❑ Chest Pain ❑ Palpitations ❑ Slow Heart Rate
❑ Leg Swelling ❑ Fast heart rate ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

❑ None ❑ Cough ❑ Wheezing ❑ Shortness of Breath
❑ Trouble breathing with exertion ❑ Trouble breathing when lying flat

Gastrointestinal

❑ None ❑ Abdominal Pain ❑ Constipation ❑ Diarrhea
❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Blood in stool

Skin

❑ None ❑ Acne ❑ Itching ❑ Change in mole
❑ Skin Lesions ❑ Skin Wound ❑ Breast Lump

Neurological

❑ None ❑ Limb Weakness ❑ Confused ❑ Loss of Memory
❑ Convulsions ❑ Headaches ❑ Dizziness ❑ Difficulty Walking

Psychiatric

❑ None ❑ Suicidal ❑ Anxiety ❑ Disturbed Sleep
❑ Depression ❑ Emotional Problems ❑ Change in Personality

Endocrine

❑ None ❑ Hair Loss ❑ Weak Muscles ❑ Hot Flashes
❑ Feeling Weak ❑ Deepening Voice

Hem/Lymph

❑ None ❑ Easy Bleeding ❑ Easy Bruising ❑ Swollen Glands

AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Low Country Radiation (LCR), a division of American Oncology Partners (AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my LCR/AOP electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

_____

Patient Name (Print)

_____

Patient or Guarantor (Signature)

_____

Date

REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

_____

_____

Name and address of practitioner

To be sent to Low Country Radiation: *(Internal use)*

_____

Address, City, State, Zip Code

_____

Fax/Telephone Number

_____ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Low Country Radiation (LCR), a division of American Oncology Partners (AOP), to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_____DISCLAIMER: Not signing does not prevent me from receiving care.

_____ _____

Patient Name (Print) Date

_____

Patient Date of Birth

_____ _____

Patient or Guarantor (Signature) Date

Patient Name: _____ **DOB:**_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

❑ **I give permission to the employees of Low Country Radiation (LCR), a division of American Oncology Partners (AOP), to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

❑ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

Patient Name: _____ **DOB:**_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Secondary Insurance Carrier:_____

Name of secondary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder:_____

Policy#/Bin# _____

I certify that the information provided is accurate. I will notify Low Country Radiation (LCR), a division of American Oncology Partners (AOP), of any changes as soon as they become available. I understand that it is my responsibility to update us of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

_____ _____

Patient Name (Print) Date

_____

Patient or Guarantor (Signature)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Low Country Radiation (LCR), a division of American Oncology Partners (AOP), Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any LCR/AOP facility or by submitting a request in writing to the corporate office at Low Country Radiation, a division of American Oncology Partners, 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting **AONcology.com/policies/LCR_NPP.pdf**

Date:_____

_____	_____
Patient Name (Print)	DOB
_____	_____
Patient (Signature)	Date
_____	_____
Patient or Guarantor (Signature)	Date

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICIES AGREEMENT

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Low Country Radiation (LCR), a division of American Oncology Partners (AOP), Financial Policies Agreement.

This notice is available in hard copy by verbally requesting a copy at the front desk of any LCR/AOP facility or by submitting a request in writing to the corporate office at Low Country Radiation, a division of American Oncology Partners, 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Financial Policies Agreement by visiting **AONcology.com/policies/LCR_FPA.pdf**

Date:_____

_____	_____
Patient Name (Print)	DOB
_____	_____
Patient (Signature)	Date
_____	_____
Patient or Guarantor (Signature)	Date

By signing below, I authorize Low Country Radiation (LCR), a division of American Oncology Partners (AOP), its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized LCR/AOP texting/email service vendor) to contact me by SMS text message or email for health-related notifications, including appointment reminders, billing communications, and to provide feedback to serve me better.

I understand that I may be receiving communications related to my information (name and email address) for marketing purposes, including from third parties and/or an online resource for patients to provide feedback regarding my care. I understand that message/data rates may apply to messages sent by LCR/AOP under my cell phone plan.

I know that I am under no obligation to authorize LCR/AOP to send me text messages and/or email. I may opt-out of receiving these communications at any time by responding with "STOP" or by unsubscribing.

I understand that text messages and/or email are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile and/or email accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services and email notifications.

PLEASE MARK THE FOLLOWING:

❑ I consent to receiving information via text and/or email. I understand I can withdraw my consent at any time.
Text Cell # _____ Email _____

❑ I do not consent to receiving any information via text and/or email. I understand that I can change my mind and provide consent later.

_____ _____
Patient Name (Print) Date

_____
Patient (Signature)