



GEORGIA CANCER SPECIALISTS

NEW PATIENT INFORMATION

PATIENT'S NAME: _____ DOB: _____ TODAY'S DATE: _____

Name(s) of Physicians you are currently seeing and telephone number:

Medical Conditions (List with dates and locations):

Surgery(s) (List with dates and locations):

Allergies:

Current Medications (name, dosages and time per day):

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Date of last menstrual cycle: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Are you disabled? **Yes** **No** If yes, date disability began: _____

Do you have any outside agencies helping in your home (visiting nurse, clergy, etc)? **Yes** **No**

Name: _____ Phone: _____

Name: _____ Phone: _____

Re: 5-24-11 tj

Appointment Date: _____
 PSR Initials: _____

PATIENT INFORMATION SHEET
 GEORGIA CANCER SPECIALISTS

Updated on 3-6-12tj

| | | | | | |
|-------------------------------|--|------------------|-------------------|--------------------|------------|
| GCS Office Location: _____ | | Pre-Reg _____ | Not Pre-Reg _____ | Update _____ | Date _____ |
| GCS Physician: _____ | | Diagnosis: _____ | | | |
| Referring Physician: _____ | | First Name _____ | Last Name _____ | Phone Number _____ | |
| Primary Care Physician: _____ | | First Name _____ | Last Name _____ | Phone Number _____ | |

PATIENT'S INFORMATION (PLEASE PRINT CLEARLY)

| | | | | |
|---|-------------------|--|--|---|
| PATIENT'S NAME (LAST) (FIRST) (MI) | | SOCIAL SECURITY NO. | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| PATIENT'S HOME ADDRESS | | | CITY | STATE |
| HOME PHONE NUMBER | CELL PHONE NUMBER | MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LIFE PARTNER <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | RACE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER: | |
| PATIENT'S EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> NONE <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY | | PATIENT'S WORK NUMBER | ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO | |
| EMPLOYER'S NAME & ADDRESS | | OCCUPATION | EMAIL ADDRESS | PREFERRED LANGUAGE |

INSURANCE INFORMATION

| | | | | |
|---|--|---|--|--|
| NAME OF FIRST INSURANCE / PHONE NUMBER | | NAME OF SECOND INSURANCE / PHONE NUMBER | | |
| NAME OF INSURED PERSON | RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Life Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ | NAME OF INSURED PERSON | RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Life Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ | |
| INSURED PERSON'S SOCIAL SECURITY NUMBER / INSURED DATE OF BIRTH | | INSURED PERSON'S SOCIAL SECURITY NUMBER / INSURED DATE OF BIRTH | | |
| EMPLOYER NAME | GROUP NAME & NUMBER | EMPLOYER NAME | GROUP NAME & NUMBER | |
| POLICY, CERTIFICATE OR ID NUMBER | PHONE NUMBER | POLICY, CERTIFICATE OR ID NUMBER | PHONE NUMBER | |

OTHER RESPONSIBLE PARTY'S OR SPOUSE'S OR SIGNIFICANT OTHER'S INFORMATION

| | | | | |
|--|--|---------------------|---------------|---------------------|
| NAME (LAST) (FIRST) (MI) | | SOCIAL SECURITY NO. | DATE OF BIRTH | RELATION TO PATIENT |
| HOME ADDRESS | | CITY | STATE | ZIP |
| EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____ <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY | | PHONE NUMBER | OCCUPATION | |
| EMPLOYER'S NAME & ADDRESS | | | CITY | STATE |
| | | | ZIP | |

EMERGENCY CONTACT PERSON'S INFORMATION

| | | |
|--------------------------|---------|---|
| NAME (LAST) (FIRST) (MI) | ADDRESS | PHONE NUMBERS <input type="checkbox"/> HOME _____ <input type="checkbox"/> WORK _____ |
| RELATIONSHIP TO PATIENT | | |

SERVICES

GEORGIA CANCER SPECIALISTS I, P.C. SUPPORTS THE USE OF MID-LEVEL PROVIDERS. YOU MAY BE SEEN PERIODICALLY BY A NURSE PRACTITIONER AND/OR PHYSICIAN ASSISTANT AND BILLED APPROPRIATELY.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance or any other health plan to Georgia Cancer Specialists I, P.C. I request that payment of such benefits be made on my behalf directly to Georgia Cancer Specialists I, P.C. I understand that I am financially responsible for all charges whether or not paid by said insurer(s). I agree to pay for all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible. I hereby authorize Georgia Cancer Specialists I, P.C. to release any information necessary to determine eligibility and/or reimbursement for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

XX Patient Signature _____ **Date:** _____



Patient name: _____ Date: _____

Please read the following important information

The physicians and staff of Georgia Cancer Specialists I, P.C. believe that it is important for all of us to consider our wishes for extraordinary medical care in the event of an unexpected, life threatening medical problem. This decision is best considered when we are well. Our state legislature understands that it is important for us to make our own decisions about medical care even when we become unable to make or communicate decisions. The Georgia Legislature has provided a way to indicate our wishes called the **Georgia Advance Directive for Health Care**. We have included information about Advance Directives in our Patient Information booklet. We will be happy to provide you with a sample of the Georgia Advance Directive for Health Care form upon your request. In addition, your nurse and physician are available to discuss any information, questions, or concerns you may have about Advance Directives.

As a new patient to Georgia Cancer Specialists I, P.C., our staff will ask you whether you have signed an Advance Directive. Your response on this form will be recorded in your medical record. If you have already signed legal documents that explain your Advance Directives, our staff will request a copy of the documents for your medical record. These documents will help your family and our staffs to make sure that your wishes are carried out in the event of a sudden problem, which prevents you from expressing your wishes at that time.

Of course, your decision to sign an Advance Directive will in no way change the care that anyone at Georgia Cancer Specialists I,P.C. provides to you and your family.

Please indicate your current choice regarding Advance Directives:

____ I **have signed** an Advance Directive and **will provide a copy** to Georgia Cancer Specialists I, P.C. I understand that the staff and physicians of Georgia Cancer Specialists I, P.C. will not be able to follow the terms of my Advance Directive until I provide them with a copy of the legal document.

____ I have **not** signed an Advance Directive, but **would like** additional information.

____ I have **not** signed an Advance Directive and **do not** wish further information at this time.

Patient Signature

Date



GEORGIA CANCER SPECIALISTS

GENERAL CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

During the course of my care and treatment, I understand that various types of tests; diagnostic or treatment procedures may be necessary and will be performed by a GCS Healthcare Professional.

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative procedures.

If I have any questions or concerns regarding these procedures, I will ask the GCS healthcare professional to provide me with additional information. I also understand that they may ask me to sign additional Informed Consent documents. The Procedures may include the following risks:

- (1) **Physical tests, assessments, and treatments** may include vital signs, internal body examinations, wound cleaning, wound dressings, range of motion checks, and other similar procedures. The material risks associated with these types of procedures include, but are not limited to, allergic reactions and infections. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.
- (2) **Drawing Blood, Bodily Fluids or Tissue Samples** that may be done for laboratory testing and analysis. The material risks associated with these types of procedures include, but are not limited to infection and bleeding. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
- (3) **Needle Sticks for Tests or for Administration of Medications**, such as injection whether intramuscularly, intravenously, subcutaneous, or intradermally. The material risks associated with these types of procedures include, but are not limited to, nerve damage, infection, allergic reaction and infiltration (which is fluid leakage into surrounding tissue). Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any procedure.

The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the procedures; therefore I agree to provide accurate and complete information about my medical history and conditions.

By signing this form, I consent to Georgia Cancer Specialists Healthcare Professionals (HP) to perform procedures as they may deem reasonable, necessary or desirable in the exercise of their professional judgment, **including those procedures that may by unforeseen or not known to be needed at the time this consent is obtained**; and I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures, and practical alternatives to the procedures.

Date Signed: _____

Printed Name of Patient: _____

Signature of Patient: _____
(or other person authorized to sign):

Reason Patient Unable to Sign: _____
(if applicable)

Relationship to Patient: _____
(if other than patient giving consent)

Consent Translated for a Non-English Speaking Patient: **Yes or No**

Name of Translator: _____

Explained By: _____
(Name and Relationship):

Language to Which Translated: _____

Signature of GCS HP: _____

Printed Name of GCS HP: _____



GEORGIA CANCER SPECIALISTS

PATIENT FINANCIAL RESPONSIBILITIES

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs and participate with Medicare. We have contracts with these insurance carriers, as you do with your carrier, which obligate us both to certain requirements.

If you are enrolled in **Medicare**, we are obligated by law to attempt to collect your co-insurance. Medicare has a fee schedule that we must abide by. Medicare reimburses us 80% of the allowed amount and expects you to pay the other 20%. If you have a medigap plan, the secondary will pay your 20%. You are also expected to pay your deductible at the beginning of the year.

If you are enrolled in a managed care plan, you are required to pay a co-payment at the time you receive services. This amount varies by insurance plan and the type of service you are receiving. As we are a specialty service, you must be referred to us by your primary care physician, who must provide us with a referral number. Many of the plans also require that we obtain a pre-certification number authorizing us to perform services other than a normal office visit, such as chemotherapy and hospital services. Unless these **referral and pre-certification** numbers are obtained prior to providing services, no payment will be made. To assist you, Georgia Cancer Specialists provides a department that makes calls to verify your insurance requirements and to obtain these numbers, but it is often very difficult to get a response. Please assist us by requesting a referral number from your primary care physician ensuring that we have these numbers prior to your visit. Be aware that there are also **Medicare and Medicaid managed care** programs available that also have these requirements.

If you have a **secondary insurance plan**, we will file one copy for your benefit. However, we will **not** follow up to see if they have received the claim or to insure that the company pays us. Please keep your primary Explanation of Benefits to re-file a claim to your secondary, should there be problems. In 90 days we will turn this balance over to you if we have not received payment.

If you are a cash patient or have a patient balance on your account, please speak to your financial counselor (if available) or call our billing office at 770-491-3610 to set up a payment plan.

Notify us immediately if you obtain new insurance or your insurance changes.

Georgia Cancer Specialists utilizes the services of a **billing agency, The Trillium Group**. If you have questions regarding your bill, please contact them at **770-491-3610**. Leave your full name and a brief message regarding the questions you have. They will review your account and call you with a response to your questions.

I have read and understand my financial responsibilities as stated above and agree to accept them as described.

Signature: _____

Date: _____



GEORGIA CANCER SPECIALISTS

Authorization to Provide Contracted Services

During your care at Georgia Cancer Specialists I, PC (GCS), your physician may prescribe medications and diagnostic tests. You have the option of receiving these services from the provider of your choice.

Pharmacy Services:

GCS has the ability to provide you with many prescribed medications. These medications will be dispensed to your physician, (acting as your representative) and transferred to you if you desire. **A pharmacist is available to provide you with counseling concerning your medications.**

In addition to receiving medications through GCS, the following pharmacies are available locally and may dispense your medications if desired: CVS 1-800-746-7287, Eckerd's 1-800-325-3737, Walgreen's 1-800-289-2273 or various independent pharmacies.

Imaging Services:

While under the care of GCS, your physician may prescribe diagnostic tests such as PET/CT, CT or Echocardiography (echo) to evaluate your condition. GCS offers PET/CT scans through Decatur PET Imaging, LLC (DPI), a facility in which GCS has an investment interest. GCS also has an investment interest in CT and echocardiography services in offered in certain GCS offices.

Decatur PET Imaging, LLC
2774 North Decatur Rd
Decatur, GA 30033
404-299-2887

GCS staff will assist you in scheduling your test if you choose to have these services performed by DPI, GCS or another provider.

By signing this document, I understand that I have the option of receiving my prescriptions or diagnostic tests from the provider of my choice **and** that I acknowledge that I received Notice of Privacy Practices (NOPP) on this date or on a previous date required by the pharmacy's Notice of Privacy Practices required by the Health Insurance Portability and Accountability Act (HIPAA).

Patient Signature: _____

Date: _____