UNITED ONCOLOGY

# PATIENT INFORMATION

Patient Name _____ DOB (mm-dd-yyyy) _____

Sex Assigned At Birth M_____ F_____

Race

□ Black or African American
□ Asian
□ White
□ Native Hawaiian or Other Pacific Islander
□ American Indian/Alaska Native
□ Other
□ Prefer Not to Answer

Ethnicity _____ Preferred Language_____

□ Prefer Not to Answer

Social Security # _____ Marital Status _____

Address _____

City/State/Zip _____

Please enter and check preferred method of contact:

- □ Home Phone _____
- □ Cell Phone _____

Email Address _____

Emergency Contact _____ Phone _____

Primary Care Physician _____Phone _____

Referred By: _____

**Patient Signature: _____ Date: _____**

24953 Paseo De Valencia, Ste. 25B, Laguna Hills, CA 92653
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# AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL RECORDS

**Treatment will not be conditioned on my providing or refusing to provide this authorization.**

**I hereby authorize and request the below healthcare provider:**

_____

**(Name of Healthcare Provider, Phone, Fax)**

**To release medical records in their possession**

TO: UNITED ONCOLOGY, HOWARD CHENG MD Fax: (949) 770-2991

**Release and/or disclose records and information regarding:**

_____/_____

**Name of Patient** **Date of Birth**

**The purpose of record release is at the request of the individual.**

**SPECIFIC RECORDS TO BE RELEASED AND/OR DISCLOSED:**

[ ] General Medical Information

[ ] Labs

[ ] Pathology

[ ] Radiology: CT, Ultrasound, MRI

[ ] Chemo Flow Sheets

[ ] Other:

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and no longer protected by HIPAA.

This authorization will expire five years from date of signature unless sooner revoked. I understand that I may revoke this authorization at any time by notifying Provider in writing, except that revocation will not apply to information that has already been released before the revocation is received by Provider. A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. This copy is for me to keep.

_____ _____ _____

**Signature of Patient or Pt's Representative** **Relationship (if not pt)** **Date**

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# CANCELLATION POLICY

Patients who have no showed for 3 office visits will be released as a patient of United Medical Doctors as per office policy. A no show appointment is defined as patients who have not called in advance to cancel their appointment. Messages left with answering service or through the voicemail are not acceptable forms of cancellation. A verbal confirmation to cancel appointment must be made in advance with a staff member of the office.

# PROCEDURE CANCELLATION POLICY

**A procedure cancellation for treatment without a 3 day advance notice will result in a charge of $150 as per office policy.**

**An office cancellation without a 3 day advance notice will results in a charge of $50 as per office policy.**

Thank you in advance for your cooperation on this matter.

**Patient Name: _____ Date: _____**

**Patient Signature: _____ Office Rep: _____**

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# Medical Information Release Form
## (HIPAA Release Form)

Name: _____ Date of Birth: _____

[ ] I authorize the release of information including the diagnosis, records, examination and claims information.
This information may be released to:

[ ] Spouse: _____ Phone number: _____

[ ] Child(ren): _____ Phone number: _____

[ ] Other: _____ Phone number: _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

**Messages**

Please call: [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signature: _____ Date: _____

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# ASSIGNMENT OF BENEFITS

**MEDICARE BENEFIT ASSIGNMENT:**

I request that payment of authorized MEDICARE BENEFITS be made to UNITED MEDICAL DOCTORS and/or HOWARD CHENG MD

I request that payment of authorized MEDIGAP BENEFITS be made to UNITED MEDICAL DOCTORS and/or HOWARD CHENG MD

**I HAVE READ THE ABOVE INFORMATION AND I UNDERSTAND MY FINANCIAL OBLIGATION TO UNITED MEDICAL DOCTORS and/or HOWARD CHENG MD**

_____

**Patient Signature** **Date**

**ALL INSURANCE BENEFIT ASSIGNMENT:**

I hereby authorize payment directly to my physician for medical services rendered. I understand that I am financially responsible for any balance not covered by my insurance carrier.

_____

**Patient Signature** **Date**

**ADDITIONAL NOTICE:**

- HMO patients are responsible to obtain the appropriate authorizations from their primary providers before they are seen in the office.
- Prior to starting treatment we require that any deductible, coinsurance or out of pocket amounts that have not yet been met for the policy year be paid in advance.
- I understand that if I do not have insurance or am not eligible at the time of service that payment is required to be paid in full at time of service.

_____

**Patient Signature** **Date**

# RELEASE OF BILLING

**AUTHORIZATION TO RELEASE INFORMATION:** I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in ITEM 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown.

_____

**Patient Signature** **Date**

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## FINANCIAL RESPONSIBILITY

On occasion your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- Not a Covered Benefit - is not covered or only partially covered by your insurance plan, also excluded may be work injury or auto accidents.
- Not deemed medically necessary - not provided as the result of illness or injury.
- Before or after Eligibility - services provided during a period your policy is not in effect.

_____

**Patient Signature** **Date**

## LAB AGREEMENT

We would like to inform you that all lab specimens drawn in our offices for tests other than a complete blood count are sent to our internal laboratory, United Medical Doctors Labs, or to outside laboratories. Our office only sends to United Medical Doctors Labs, Quest and Lab Corp and we use Neogenomics for specialty tests.

A minority of our patients are covered by insurance companies that contract with specific laboratory that is not one of the above. In these cases, the patient may incur additional costs for labs drawn at our offices. If such is the case with you, please request a written lab order so your tests can be performed at a contracted laboratory.

By signing this form, you indicate understanding of this disclosure:

_____

**Patient Signature** **Date**

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# PATIENT COMMUNICATION EMAIL AUTHORIZATION FORM

I, _____, hereby authorize McKesson Specialty Health Technology Products, LLC (d/b/a "Ontada"), a third party acting on behalf of Dr. Howard Cheng/United Medical Doctors, to communicate with me via email for purposes related to my treatment, payment for health care, and/or healthcare operations, I understand and agree to the following terms:

**Email Communications:**

I consent to receive electronic communications from Ontada at the email address provided below. These communications may include registration links, treatment updates, and other relevant healthcare information.

**Email Address:** _____

**Communication Frequency:**

I understand that the frequency of communications may vary depending on my treatment and healthcare needs.

**Updating Contact Information:**

I will promptly inform the Practice in case of any changes to my contact information to ensure accurate and timely communications.

**Opting Out:**

I retain the right to opt out of receiving emails from Ontada at any time. I can adjust my communication preferences in my Ontada account if I have registered for an account.

By signing this Patient Communication Email Authorization Form, I confirm that I have read and understood the terms of this authorization, and I voluntarily grant Ontada the permission to communicate with me via email for purposes related to my treatment, payment for care, or healthcare operations on behalf of the Practice.

_____

**Patient Signature** **Date**

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# NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**If you have any questions about this Notice please contact our Privacy Officer who is Krystal Farias**

**This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.**

**We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.**

## JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
**PLEASE REVIEW IT CAREFULLY**

United Medical Doctors participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants within the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be accessed at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.

The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals.

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**NOTICE OF PRIVACY PRACTICES CONT.**

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**1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

**Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.**

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not

want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object**

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care

system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims

of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object**

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**NOTICE OF PRIVACY PRACTICES CONT.**

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We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**2. YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

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**NOTICE OF PRIVACY PRACTICES CONT.**

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Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **written request to your physician.**

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice electronically.

**3. COMPLAINTS**

**You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.**

You may contact our Privacy Officer, **Krystal Farias** at **(951) 566-5229** or **krystal.farias@unitedgi.com** for further information about the complaint process.

This notice was published and becomes effective on January 1, 2013**.**

**Printed Name: _____**

**Signature: _____ Date: _____**

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# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

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**Article 4: General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

**Effective as of the date of first medical services.** _____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

By: _____ _____
United Medical Doctors Authorized Representative's Signature (Date)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

UNITED ONCOLOGY

# Patient Interview Form

Allergies:_____
_____
_____

Current Medications (include dose and how it is taken):

| Name | Dose/Frequency | How It Is Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Preferred Pharmacy/Location:_____

Please list any conditions or chronic illnesses you may have:

1._____
2._____
3._____
4._____
5._____
6._____

Please list any operations you have had:

1._____Date_____
2._____Date_____
3._____Date_____
4._____Date_____
5._____Date_____
6._____Date_____

| **Family History:** | **Alive (Age)** | **If deceased, age of death** | **Cause of death** |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| Sister(s) | | | |
| Children | | | |

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**Do you have any family history of:**

Cancer, Bleeding Disorders or blood clots? _____

If so, please list the relative and the condition below: _____
_____
_____
_____
_____

**Social History**

Current Occupation: _____ # of Children:_____

Past Occupations: _____
_____
_____
_____

Retired? YES / NO

Current Martial Status (please circle): Single – Married – Divorced – Separated

Who do you live with? _____
_____
_____
_____

Where were you born and raised? _____

Religion? _____

**Alcohol**

- □ None
- □ Less than 7 drinks weekly
- □ 7-14 drinks weekly
- □ More than 14 drinks weekly
- □ Former alcohol abuse, now sober

**Do you smoke?** **YES** **NO**
Average # of cigarettes per day? _____
If you stopped, when? _____
How many years did you smoke? _____

**Drug Use** **YES** **NO**
Past use, type:_____
Current use, type:_____

UNITED ONCOLOGY

**System Review:**

Weight Now: _____ 3 Months Ago: _____ One Year Ago:_____

General Health:_____

**Do you experience these regularly or frequently?**

Head & Neck

Y / N Severe or frequent headaches
Y / N Double vision
Y / N Blurry Vision
Y / N Ringing in ears
Y / N Sore throat
Y / N Hoarseness
Y / N Runny nose
Y / N Nasal congestion

Gastrointestinal

Y / N Trouble swallowing
Y / N Frequent or severe abdominal pain
Y / N Diarrhea
Y / N Nausea
Y / N Vomiting
Y / N Yellow Jaundice
Y / N Abdominal pain
Y / N Bloody or black stool
Y / N Chronic constipation
Y / N Pencil thin stool

Musculoskeletal

Y / N Bone pain
Y / N Muscle pain
Y / N Joint pain/swelling
Y / N Back Pain

Skin

Y / N Rash
Y / N Itching
Y / N Skin cancer

Allergy / Immunologic

Y / N Frequent infections
Y / N Pollen allergies

Genitourinary

Y / N Urine Incontinence
Y / N Pain with urination
Y / N Blood in urine
Y / N Frequent urination in the day

Cardiopulmonary

Y / N Cough
Y / N Coughing up blood
Y / N Wheezing
Y / N Shortness of breath
Y / N Chest pain
Y / N Sitting up at night to catch breath
Y / N Rapid heartbeat
Y / N Swollen ankles

Gynecological

Y / N Heavy periods
Date of last pap smear _____ Doctor_____
# Pregnancies: ___ Miscarriages:___ Births:___
Contraception used: Y / N Type: _____
Date of last period: _____

Neuropsychiatric

Y / N Seizures/Epilepsy
Y / N Dizzy/spinning sensation
Y / N Speech difficulties
Y / N Gait/balance difficulties
Y / N Numbness of extremities
Y / N Tingling of extremities

Hematologic

Y / N Bleeding
Y / N Bruising

Lymphatic

Y / N Enlarged lymph nodes

Constitutional

Y / N Fevers
Y / N Drenching night sweats
Y / N Severe fatigue

Genitourinary Cont.

Y / N Frequent urination at night
Y / N Difficulty initiating urine
Y / N Slow urine stream

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