WEEKS CANCER CENTER

DR. ALBERT EARLE WEEKS, MD LORETTA SHAMLEY, NP

NEW PATIENT FORMS

Date of Visit _____ Referring Provider _____ Insurance _____

Patient Name _____ DOB _____

Phone _____ Email _____

Pharmacy _____ Phone _____ Location _____

REASON FOR VISIT IN DETAIL

_____

Any recent test/ labs done ? YES / NO if yes Where? _____

Pain level if any (please circle): [Least] 0 1 2 3 4 5 6 7 8 9 10 [Most]

Please list any other physicians you currently see

Physician name_____ Specialty_____

Physician name_____ Specialty_____

Physician name_____ Specialty_____

Are you under the care of a **Cardiologist**? YES / NO Doctor name: _____

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ALLERGIES/ MEDICATIONS

Are you allergic to latex? YES / NO Have you had vaccinations? YES / NO

If yes,? □ Flu □ Other _____

Medications (attach list if needed)

_____

_____

_____

_____

Allergies and Reactions

_____

_____

_____

_____

SOCIAL HISTORY

Occupation _____

Marital Status(please circle) Single Married Divorced Widowed

Lives with ? _____

Do you have your own transportation? YES / NO

PAST SURGERIES

□ None (Please check if none)

Surgery	Date of Surgery	Hospital performed at

Do you have any surgical hardware?

___ Hip ___Valve ___Pacemaker ___ Defibrillator ___ Aneurysm Clip

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MEDICAL HISTORY

Past and Present Illnesses (CHECK ALL THAT APPLY)

Heart and blood vessels	Yes	How Long?	Kidney /Bladder	Yes	How Long?
Anemia			Kidney Disease (On Dialysis)		
Angina			Kidney Stones		
Heart Attack			Urinary Tract infection		
Heart Disease/Failure			**Blood Disorders**		
High Blood Pressure			Bleeding w/tooth extraction		
Peripheral Vascular Disease			Blood Clots/Clotting Disorder		
Stent Placement			Easy Bruising		
Stroke/TIA			**Immune System**		
Brain and Nerves			Other collagen Vascular Disease		
Glaucoma			Human Immune Virus(HIV)		
Migraines			Lupus		
Multiple Sclerosis			**Joint/Skeleton**		
Parkinson's Disease			Arthritis		
Seizures or Epilepsy			Rheumatoid Arthritis		
Lungs			**Endocrine**		
Chronic Bronchitis			Diabetes or Sugar Issues		
Emphysema/COPD			Thyroid Disease or Goiter		
Pneumonia			**Psychological**		
Sleep Apnea			Anxiety		
Tuberculosis (TB)			Depression		
Stomach/Intestines			Psychiatric Treatment		
Colitis			**Other**		
Crohn's Disease			GYN problems		
Diverticular Disease			Hepatitis/Liver Disease		
			Sinusitis		

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OTHER MEDICAL HISTORY

Medical condition(s)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL CANCER HISTORY

Please complete regarding the treatment of your prior cancer(s)

Cancer Type		Yes/No	Date Treated	Treating Physician
	Did you receive chemotherapy?			
	Did you have surgery?			
	Did you have radiation?			
	Did you receive chemotherapy?			
	Did you have surgery?			
	Did you have radiation?			
	Did you receive chemotherapy?			
	Did you have surgery?			
	Did you have radiation?			

FAMILY HISTORY

MOTHER _____ **OTHER** _____

FATHER _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name _____

Address _____

Date of Birth _____ Social Security No. _____

I hereby authorize WEEKS CANCER CENTER PLLC, to release or obtain all health information about me from:

Name _____
Address _____
Phone: _____ Fax: _____

WEEKS CANCER CENTER,PLLC is hereby authorized to receive my entire medical record, treatment record, and diagnostic record to the following persons or organization:

The following health information that relates to service beginning from my first visit to current, may be released:

- Entire medical records (including patient histories, office notes (expect psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

I further understand that my medical record may include on or more of the following:

- all medical records

I understand and agree that my health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by the law. This authorization is valid for 99 years following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/ organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (I have had to read to me) this authorization, and I agree to its terms as indication by my signature below. I am entitled to a copy of this authorization.

_____ _____ _____

Patient's Signature Patient's Name Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to communicate appointments, etc? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____Date of Birth _____
(PRINT NAME PLEASE)

Signature: _____Date:_____

Witness: _____Date: _____

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Consent for Treatment / Assignment of Benefits Form

Consent for Treatment: WEEKS CANCER CENTER, PLLC strives to provide the best in the most reasonable care in a patient centric fashion. To achieve that I understand WEEKS CANCER CENTER, PLLC can deploy diagnostic and therapeutic testing or interventions as indicated.

These diagnostic and or therapeutic interventions as and when needed. Other testing and or interventional procedures may be needed from time to time.

I understand that vast majority of these diagnostic and or therapeutic procedures are extremely safe nevertheless there always remains some risk of pain, infection, bleeding damage to internal organs.

I hereby give permission and consent to WEEKS CANCER CENTER, PLLC deploy diagnostic and/or therapeutic interventions as needed in my case to achieve the best diagnosis and treatment. This is my consent for treatment. I can withdraw my consent for treatment at any time by providing a written notice to WEEKS CANCER CENTER, PLLC.

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by WEEKS CANCER CENTER,PLLC including physician services, or by any provider under contract with WEEKS CANCER CENTER,PLLC or participating in a provider network in which WEEKS CANCER CENTER,PLLC or its affiliates participate.

Important Information for Patients: I received the material on each line initialed below.

Notice of Privacy Practices (unless received during previous visit)
Federal and State Patient Rights Information available at www.hhs.gov
Health Care Directive Brochure (provided upon request)

Guarantee and Agreement to Pay NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below. I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that interest per year may be added if the account balance goes to a collection agency.

_____ _____

Signature of Patient, or if Patient is unable to sign, a Representative of the Patient

Date/Time