Norman H. Anderson M.D., P.A.

D/B/A

Robert Boissoneault Oncology Institute

2020 SE 17th Street
Ocala, Fl 34471

522 N. Lecanto Highway
Lecanto, FL 34461

605 W. Highland Blvd.
Inverness, FL 34452

9401 SW Hwy 200
Bldg. 800
Ocala, FL 34474

1400 US Hwy 441 North
#300
The Villages, FL 32159

INSURANCE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

I request that the payment of authorization benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for me.

I request that this authorization also apply to all other insurance.

_____

Signature *Date*

_____

Patient's Printed Name

_____

BY: (if other than patient)

Notice of Privacy Practices

Acknowledgement of Receipt

I understand that, under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly
- Electronically exchange records with other healthcare providers and organizations
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis
- Access drug benefit coverage and medication history

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____ Date: _____

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of RBOI Rep. _____ Date: _____

Robert Boissoneault Oncology Institute
Dania Neveau – HIPAA Compliance Officer
2020 SE 17th Street
Ocala, FL 34471
(352) 732-0277

Patient Registration

Date: _____
Name: _____
DOB: _____ Age: _____
Address: _____
_____ , _____
Home Phone: _____
Social Security #: _____

Physician Information	
Referring Physician:	
Primary Physician:	
Other Physicians:	

The following information is required by the State of Florida:

Race: ☐ American Indian / Eskimo / Aleut ☐ Black ☐ White Hispanic ☐ Other
☐ Asian / Pacific Islander ☐ White ☐ Black Hispanic ☐ No Response

Marital Status: M ☐ S ☐ D ☐ W ☐

Your Employer: _____ Work Phone: _____
Cell Phone: _____

Spouse's Name: _____ Work Phone: _____
Spouse's DOB: _____ Cell Phone: _____

Other Emergency Contact: _____ Work Phone: _____
Relationship: _____ Cell Phone: _____

List your e-mail address for access to MyHealthStory, the community patient portal: _____

How did you hear about RBOI?

☐ Referring Doctor ☐ Newspaper ☐ Phone Book Other: _____
☐ Billboard ☐ TV ☐ Internet _____

Internal Use Only

Ins. Co _____ No. of visits _____
Primary Dr. _____ Exp. Date _____
Auth No. _____

Previous or Additional Diagnosis: _____
_____
_____

Account Number: DX:
Attending:

☐ ORMC ☐ MRMC ☐ 7RS ☐ CMH ☐ LRMC ☐ Ameripath ☐ Dianon ☐ Other

Authorization for the Release of Private Health Information (PHI)

While under the care of the physicians at the Robert Boissoneault Oncology Institute, I hereby give authorization for the release of private health related information to the following authorized persons:

Physicians	Family Members (Relation)

This information may be given to the above mentioned people either by phone, fax machine, or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named persons, I will notify RBOI in writing of such names.

I authorize RBOI and staff to leave medical information pertaining to my care using the following methods and will assume responsibility to notify RBOI and staff whenever this information changes:

Home Telephone ☐

- Answering Machine ☐

Work Telephone ☐

- Voice-Mail ☐

Cell Phone and/or ☐

- Voice-Mail ☐

Date: _____ Patient Signature: _____

Initial Patient Encounter and Medication List

Date: _____

Patient Name: _____

→Pharmacy Name: _____

→Pharmacy Number: _____

Office Use Only

DOB: _____

Weight: _____

Vital Signs: _____

Karnofsky Scale: _____

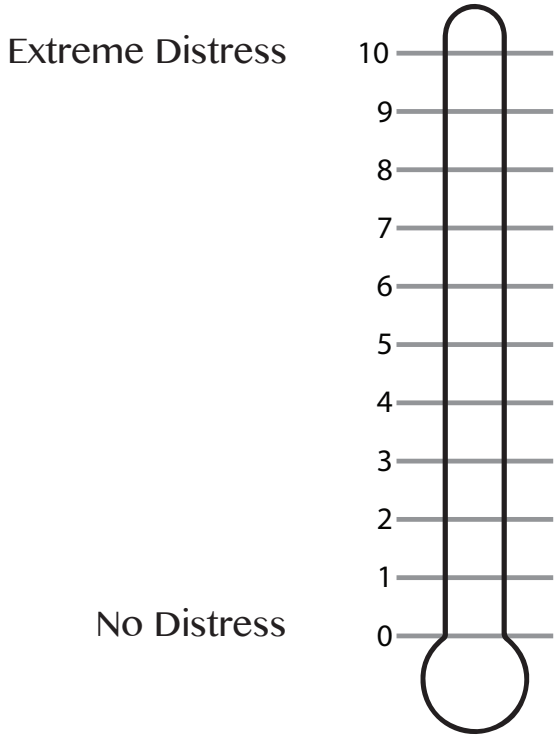
Name of Medication	Dose	How often

Allergies:

Distress Thermometer for Patients

At RBOI we feel it is important to provide care for the whole patient and family, knowing that cancer often causes distress and disruptions in your daily life. The distress thermometer allows you to notify your care team of concerns that are important to you, whether they be emotional needs or practical concerns such as transportation, work or financial needs.

First, look at the thermometer and circle the number you feel best describes the amount of distress you have been experiencing recently.
Second, review the checklist and please check yes or no to indicate if any of these items have been a concern for you
Once you are finished, please return the completed form to a member of your care team.



YES	NO	
		Practical Concerns
☐	☐	Child Care
☐	☐	Housing
☐	☐	Insurance/Financial
☐	☐	Transportation
☐	☐	Work/School
☐	☐	Treatment decisions
		Family Concerns
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Caregiving Concerns
☐	☐	Family health issues
		Emotional Concerns
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**Spiritual/Religious Concerns**

Other: _____

_____

_____

You will be contacted by our social worker who reviews the thermometer and is here to address your concerns.
If you have any questions or would like to talk with the Social Worker as soon as possible, please let us know during your visit TODAY. Amy K Roberts and Wendy Hall

Robert Boissoneault Oncology Institute:
Patient Medical History

Do you have or have you had any of the following conditions?	Check for YES	Year Diagnosed
Cancer (other than for this visit) ……	☐	
Heart Disease ……	☐	
High Blood Pressure ……	☐	
Pacemaker ……	☐	
Reflux or GERD ……	☐	
Stomach Ulcers ……	☐	
Diabetes ……	☐	
Arthritis ……	☐	
Stroke ……	☐	
Lung Disease (☐ asthma ☐ emphysema ☐ pneumonia) ……	☐	
Prostate Disease ……	☐	
Bladder Disease ……	☐	
Kidney Disease ……	☐	
Liver Disease ……	☐	
Seizures ……	☐	
Mental Illness (nervous condition / depression) ……	☐	
Other serious medical condition: ……	☐	
Are you allergic to any medications? If yes, please list:		

_____

_____

		When?
Any other notable allergies? ……	☐	
Have you had any major accidents or injuries? ……	☐	
Have you had a colonoscopy? ……	☐	
Do you have a DNR (Do not resuscitate) order? ……	☐	
Do you have a Living Will? ……	☐	

Past Surgical History — List all major operations you have had:	Date

Cancer Treatment History

Have you ever had radiation or x-ray treatments? …… ☐ YES ☐ NO _____

Area of body: _____ Facility and city where treated: _____

Have you ever had chemotherapy? …… ☐ YES ☐ NO _____

Prostate Screening (Males)

Recent PSA and/or digital rectal exam? …… ☐ YES ☐ NO _____

Do you have a family history of prostate cancer? …… ☐ YES ☐ NO _____

Influenza Vaccine

Have you had a flu shot? …… ☐ YES ☐ NO _____

Gynecological History (Females)

Is there any chance you could be pregnant? …… ☐ YES ☐ NO

Number of pregnancies: _____ Number of live births: _____

Age at first pregnancy: _____ Did you breast feed? ☐ YES ☐ NO

Date of last mammogram: _____ Date of last pap smear: _____

Have you ever taken birth control pills? …… ☐ YES ☐ NO

Have you ever taken hormone replacement therapy? …… ☐ YES ☐ NO

Onset of menstruation (age): _____ Age at menopause: _____

Do you have a family history of breast cancer? …… ☐ YES ☐ NO Who? _____

Family History

Relation	Age	State of Health	If deceased, cause and age of death
Mother			
Father			
Siblings:			
Spouse			
Children			

Have you ever used tobacco products? ☐ Yes ☐ No

Type? _____ How much? _____ How Long? _____ Date Quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

Type? _____ How much? _____ How Long? _____ Date Quit? _____

Are you taking medication for an under active thyroid? ☐ Yes ☐ No

Are you taking medication for elevated cholesterol or triglycerides? ☐ Yes ☐ No

Review of Systems

Have you experienced any of these problems during the past month?

☐ Weight Loss (if yes, how many pounds have you lost?) _____

☐ Fevers
☐ Chills
☐ Skin rash or itching
☐ Headaches
☐ Seizures
☐ Loss of balance or coordination
☐ Hearing loss
☐ Vision: blurred, double, loss
☐ Arm or leg paralysis
☐ Arm or leg numbness
☐ Difficulty swallowing
☐ Hoarseness or change in voice
☐ Sores in mouth or lip
☐ Shortness of breath
☐ Cough
☐ Coughed or spit up blood
☐ Mood changes or depression
☐ Frequent indigestion
☐ Nausea

☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Jaundice
☐ Rectal bleeding
☐ Blood in urine

For Men

☐ Decrease in size or force of urine stream
☐ Difficulty with sex or impotence

For Women

☐ Lump, discharge or breast pain
☐ Irregular menstrual bleeding
☐ Irregular vaginal bleeding or discharge
☐ Difficulty with sex or painful intercourse

Pain

Do you have any pain? If yes, what is the severity on a scale of 1 – 10 (10 being the worst)? _____

Location: _____

Describe the pain: ☐ Constant ☐ Intermittent ☐ Shooting ☐ Throbbing ☐ Dull ☐ Sharp ☐ Burning Other:

What makes it worse? _____

What makes it better? _____

Does medication relieve the pain? ☐ Yes ☐ No

_____
Patient or nearest of kin

_____
Relationship to Patient

Date: _____