

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: _____

Physician Information	
Referring Physician:	_____
Primary Physician:	_____
Other Physicians:	

Home Phone: _____
 Social Security #: _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____

Allergies:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

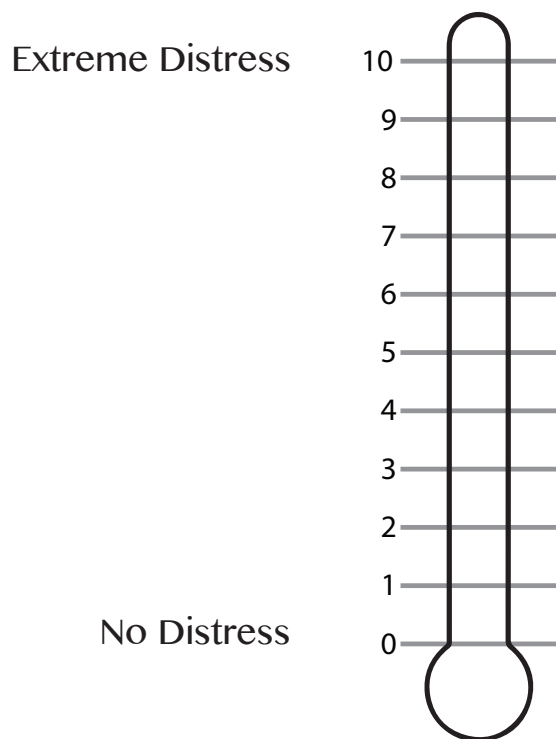
Distress Thermometer for Patients

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	<u>Practical Concerns</u>
<input type="checkbox"/>	<input type="checkbox"/>	Child Care
<input type="checkbox"/>	<input type="checkbox"/>	Housing
<input type="checkbox"/>	<input type="checkbox"/>	Insurance/Financial
<input type="checkbox"/>	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	<input type="checkbox"/>	Work/School
<input type="checkbox"/>	<input type="checkbox"/>	Treatment decisions
		<u>Family Concerns</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner
<input type="checkbox"/>	<input type="checkbox"/>	Caregiving Concerns
<input type="checkbox"/>	<input type="checkbox"/>	Family health issues
		<u>Emotional Concerns</u>
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Fears
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Sadness
<input type="checkbox"/>	<input type="checkbox"/>	Worry
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in usual activities
<input type="checkbox"/>	<input type="checkbox"/>	<u>Spiritual/Religious Concerns</u>
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

<u>Relation</u>	<u>Age</u>	<u>State of Health</u>	<u>If deceased, cause and age of death</u>
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?

- | | |
|---|---|
| <input type="checkbox"/> Weight Loss (if yes, how many pounds have you lost?) _____ | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Skin rash or itching | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Loss of balance or coordination | |
| <input type="checkbox"/> Hearing loss | |
| <input type="checkbox"/> Vision: blurred, double, loss | For Men |
| <input type="checkbox"/> Arm or leg paralysis | <input type="checkbox"/> Decrease in size or force of urine stream |
| <input type="checkbox"/> Arm or leg numbness | <input type="checkbox"/> Difficulty with sex or impotence |
| <input type="checkbox"/> Difficulty swallowing | |
| <input type="checkbox"/> Hoarseness or change in voice | For Women |
| <input type="checkbox"/> Sores in mouth or lip | <input type="checkbox"/> Lump, discharge or breast pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Irregular menstrual bleeding |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Irregular vaginal bleeding or discharge |
| <input type="checkbox"/> Coughed or spit up blood | <input type="checkbox"/> Difficulty with sex or painful intercourse |
| <input type="checkbox"/> Mood changes or depression | |
| <input type="checkbox"/> Frequent indigestion | |
| <input type="checkbox"/> Nausea | |

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: _____