

Billing & Payment Information

We are dedicated to providing the highest quality of care to all our patients without regard to financial status. Our philosophy is to provide state-of-the-art radiation therapy and follow-up care, while offering support to our patients' families through our counseling services. We wish to take this opportunity to familiarize you with our customary billing procedures.

We participate with most major insurance carriers. By providing us with all of your current and accurate insurance information upon registration, you allow us to properly submit your medical claims. Please notify us immediately should there be any changes to your primary insurance coverage (or to your secondary insurance) during the course of your care. Changes would include: change to primary or secondary insurance carrier, change to insurance plan, change to policy ID numbers (may even change with the same carrier), etc. It's very important for us to have that information. In addition, please let us know of any address, phone, or other pertinent information changes as soon as possible.

We will verify your coverage and benefits at the time we receive your information. We will obtain any applicable authorizations from your carrier or PCP. Should you be unsure of your benefits, co-pays or deductibles, we strongly encourage you to call the phone number listed on the back of your insurance card(s). It is very important for you to be familiar and understand your policy and benefits, as well as knowing what services may need prior authorization.

We process and submit all your radiation therapy charges to your insurance carrier(s) on a biweekly basis. Therefore, you may receive Explanation of Benefits statements from your insurance carrier(s) while under treatment. As your treatment is of the utmost concern to us, you will not receive a bill from our office until the completion of treatment. Payment of your co-pays, co-insurance, and deductibles are a contractual requirement by your carrier(s) and are typically requested at the time of service. However, we will not request payment of such until the end of treatment course which at that point you will receive a bill for what was not covered by your insurance carrier(s). Follow-up visits are submitted to your insurance carrier at time of visit.

We understand your concerns and we are here to help you. You have the right to examine and understand your bill, and we encourage you to do so. Your medical care is our first priority. Please do not hesitate to contact us with any questions you may have throughout this process. Good Faith Estimates for our self-pay patients are available upon request.

Questions? Please call our Billing Department at 352-861-0440

 PatientSignature/Acknowledgment: _____ Date _____

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

ROBERT BOISSONEAULT ONCOLOGY INSTITUTE

2020 SE 17th St. Ocala, FL 34471 (352) 732-0277 Fax: (352) 414-5088	522 N Lecanto Hwy Lecanto, FL 34461 (352) 527-0106 Fax: (352) 527-0585	9401 SW Hwy 200,Bldg 800 Ocala, FL 34481 (352) 861-2400 Fax: (352) 861-2401	605 W.Highland Blvd. Inverness, FL 34452 (352) 726-3400 Fax: (352) 527-0585	1540 Clemente Ct. The Villages, FL 32159 (352) 259-2200 Fax: (352) 581-6210
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Authorization for Release of Medical Records

TO: _____

You are hereby authorized to furnish Robert Boissoneault Oncology Institute with copies of the medical records compiled during my treatment in your facility and are hereby released from any legal liability that may arise from the release of the information requested, including any sensitive information or genetic testing. A photostatic copy or facsimile of this authorization is to be considered as valid as the original. Information may be transmitted by fax, in person, or e-mail and I am aware of the potential dangers of electronically transmitted information.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons or entities listed above without my further authorization, but that RBOI cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Medical Records Specialist, 2020 SE 17th St., Ocala, FL 34471. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

Patient's Name: _____

Patient's Date of Birth: _____

Age: _____

Signed: _____

Relationship to Patient: _____

Date: _____

The above named patient has cancer, and it is very important that we receive the information requested below as soon as possible to begin treatment. Thank you for your assistance.

Records Requested

Office and/or clinic notes – History and Physical
Pathology reports – Operative reports
Discharge Summary – Laboratory data
Radiology Reports
ALL X-RAY FILMS

Treatment Information Requested

Tumor dose – Daily fractions
Total treatment time – Total treatment dates
Energy used – Distance – Filtration
Port drawings or films
Treatment technique: AP, PA, rotation, etc.

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 Cossin – HIPAA Privacy 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 United States Federal Government:

Race: White Black or African American American Indian or Alaska Native Asian
 Native Hawaiian or Other Pacific Islander Hispanic Other Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Not Latino Unknown

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 ADVENT 7RS CMH LRMC Ameripath Dianon Other

Pt.Name: _____ | Pt.Number: _____

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: _____

For Office Use Only:

HT:	BP:	O2:	KPS%
WT:	PULSE:	TEMP:	

PATIENT MEDICAL HISTORY FORM:

PATIENT NAME:		DOB:	
GENDER: MALE <input type="radio"/> FEMALE <input type="radio"/>	PACEMAKER/DEFIBRILLATOR NO <input type="radio"/> YES <input type="radio"/>	INSERTION DATE	
CLAUSTROPHOBIC: NO <input type="radio"/> YES <input type="radio"/>	CHEMO PORT: NO <input type="radio"/> YES <input type="radio"/>		
PNEUMONIA VACCINE: NO <input type="radio"/> YES <input type="radio"/> : Date	FLU VACCINE: NO <input type="radio"/> YES <input type="radio"/> : Date		
COVID VACCINE: NO <input type="radio"/> YES <input type="radio"/> : Date	MODERNA <input type="radio"/> PFIZER <input type="radio"/> J&J <input type="radio"/>		
CITY & STATE OF BIRTH:	OCCUPATION:		

MEDICAL CONDITIONS & REVIEW OF SYSTEMS: (check for YES)

CONDITION	DIAGNOSIS YEAR	TREATMENT TYPE	TREATMENT DATES
<input type="radio"/> CANCER-EXCLUDING THIS VISIT			
<input type="radio"/> MELANOMA			
<input type="radio"/> HEART DISEASE			
<input type="radio"/> STROKE			
<input type="radio"/> HIGH BLOOD PRESSURE			
<input type="radio"/> ELEVATED CHOLESTEROL/ TRIGLYCERIDES			
<input type="radio"/> THYROID CONDITION			
<input type="radio"/> REFLUX / GERD			
<input type="radio"/> STOMACH ULCERS			
<input type="radio"/> DIABETES			
<input type="radio"/> ARTHRITIS			
<input type="radio"/> LUNG DISEASE (CHECK): <input type="checkbox"/> asthma <input type="checkbox"/> COPD <input type="checkbox"/> emphysema <input type="checkbox"/> pneumonia			
<input type="radio"/> PROSTATE DISEASE			
<input type="radio"/> BLADDER DISEASE			
<input type="radio"/> KIDNEY DISEASE			
<input type="radio"/> LIVER DISEASE			
<input type="radio"/> EPILEPSY			
<input type="radio"/> MENTAL ILLNESS			
<input type="radio"/> OTHER			

CONDITION(S) EXPERIENCED IN THE LAST MONTH (check for YES)

<input type="radio"/> WEIGHT LOSS	<input type="radio"/> CHEST PAIN WITH EXERTION	<input type="radio"/> PAIN WHEN URINATING
<input type="radio"/> FEVERS	<input type="radio"/> ARM OR LEG SWELLING	<input type="radio"/> HEADACHES
<input type="radio"/> CHILLS	<input type="radio"/> DIFFICULTY SWALLOWING	<input type="radio"/> SEIZURES
<input type="radio"/> SKIN RASH / ITCHING	<input type="radio"/> FREQUENT INDIGESTION	<input type="radio"/> BALANCE/DEXTERITY LOSS
<input type="radio"/> VISION CHANGES:LOSS/BLURRED/DOUBLE VISION	<input type="radio"/> NAUSEA	<input type="radio"/> DIZZINESS
<input type="radio"/> HEARING LOSS	<input type="radio"/> VOMITING	<input type="radio"/> ARM OR LEG NUMBNESS
<input type="radio"/> SORES IN MOUTH / LIP	<input type="radio"/> DIARRHEA	<input type="radio"/> ARM OR LEG PARALYSIS
<input type="radio"/> HOARSENESS/VOICE CHANGE	<input type="radio"/> CONSTIPATION	<input type="radio"/> DEPRESSION
<input type="radio"/> SPITTING UP BLOOD	<input type="radio"/> JAUNDICE	<input type="radio"/> ANXIETY
<input type="radio"/> COUGH	<input type="radio"/> RECTAL BLEEDING	<input type="radio"/> EASY BRUISING _{OR} BLEEDING
<input type="radio"/> SHORTNESS OF BREATH	<input type="radio"/> BLOOD IN URINE	<input type="radio"/> MUSCLE PAIN _{OR} SWELLING

Nurse Initials _____

Patient Name: _____ DOB: _____ Patient Number: _____

COLONOSCOPY: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> : Date _____
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FOR MEN: (check <input type="radio"/> for Yes)	<input type="radio"/> DECREASE IN SIZE OR FORCE OF URINE STREAM	<input type="radio"/> DIFFICULTY W/ SEX OR IMPOTENCE	
	PSA TEST: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> Date: _____	BONE SCAN: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> Date: _____	
	HORMONE REPLACEMENT THERAPY: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> -DATES&DRUG NAME: _____		

FOR WOMEN (GYNECOLOGICAL HISTORY):		
CHANCE OF PREGNANCY: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/>	# PREGNANCIES: _____	
AGE @ 1 ST PREGNANCY: _____	# LIVE BIRTHS: _____	
BREAST FEED: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/>	AGE @ 1 ST MENSTRUATION: _____	
AGE @ MENOPAUSE: _____	BIRTH CONTROL: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> -DATES&DRUG NAME: _____	
HORMONE REPLACEMENT THERAPY: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/> -DATES&DRUG NAME: _____		
MAMMOGRAM: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/>	IF <u>YES</u> , DATE OF LAST MAMMOGRAM : _____	
PAP SMEAR: <u>NO</u> <input type="radio"/> <u>YES</u> <input type="radio"/>	IF <u>YES</u> , DATE OF LAST PAP SMEAR : _____	
CONDITIONS (check <input type="radio"/> for Yes)	<input type="radio"/> LUMP, DISCHARGE OR BREAST PAIN	<input type="radio"/> IRREGULAR MENSTRUAL BLEEDING
	<input type="radio"/> IRREGULAR VAGINAL DISCHARGE	<input type="radio"/> DIFFICULT OR PAINFUL SEX

PRIOR RADIATION THERAPY:

CANCER DIAGNOSIS	TREATMENT DATES	TREATMENT SITE	NAME OF FACILITY & DR

CHEMOTHERAPY AND/OR IMMUNOTHERAPY:

CANCER DIAGNOSIS	DRUG NAME	TREATMENT DATES	TREATMENT SITE	NAME OF FACILITY & DR

ENDOCRINE THERAPY (HORMONE BLOCKERS):

DRUG NAME	TREATMENT DATES	TREATMENT SITE	FACILITY & DR NAME

RECENT TESTS OR HOSPITALIZATIONS (INCLUDE DATES):

SURGERIES:

TYPE OF SURGERY	DATE	HOSPITAL	REASON FOR SURGERY

Nurse Initials _____

Patient Name: _____ DOB: _____ Patient Number: _____

MEDICATIONS: (If needed, attach a separate piece of paper w/ additional list of medications)

MEDICATION	DOSE	# OF TIMES/DAY	ROUTE (ex oral)	DATE STARTED	PRESCRIBED BY

OTHER MEDICATIONS (OVER THE COUNTER MEDICINE OR VITAMINS):

MEDICATION	DOSE	# OF TIMES/DAY	DATE STARTED

OTHER DRUGS (ex. Cocaine, Heroin, Marijuana, Methamphetamine):

DRUG NAME	AMOUNT TAKEN	# OF TIMES/DAY	DATE STARTED & STOPPED

ALLERGIES:

ALLERGY	ALLERGIC REACTION / SYMPTOMS

PREFERRED PHARMACY:

PHARMACY NAME	ADDRESS	PHONE #

Nurse Initials _____

Patient Name: _____ DOB: _____ Patient Number: _____

TOBACCO USE:

SMOKING STATUS : <input type="radio"/> Current Every Day Smoker <input type="radio"/> Former Smoker <input type="radio"/> Current Some Day Smoker <input type="radio"/> Never	
# OF CIGARETTES PER DAY : <input type="radio"/> Light Smoker <input type="radio"/> Heavy Smoker (25 or more cigarettes)	
# OF PACKS PER DAY : _____	# OF SMOKING YEARS : _____
START DATE : _____	QUIT DATE (IF APPLICABLE) : _____

ALCOHOL CONSUMPTION:

DO YOU DRINK ALCOHOL? <u>YES</u> <input type="radio"/> <u>NO</u> <input type="radio"/>	# BOTTLES/GLASSES PER DAY: _____
IF YES, TYPE: _____	# BOTTLES/GLASSES PER WEEK: _____
# YEARS: _____	QUIT DATE (IF APPLICABLE) : _____

FAMILY HISTORY:

RELATION	AGE	STATE OF HEALTH (GOOD/POOR/DECEASED)	IF DECEASED, CAUSE & AGE OF DEATH
MOTHER			
FATHER			
SIBLINGS:			
SPOUSE			
CHILDREN			
FAMILY HISTORY OF PROSTATE CANCER	<u>YES</u> <input type="radio"/> <u>NO</u> <input type="radio"/>	IF <u>YES</u> , MATERNAL <input type="radio"/> PATERNAL <input type="radio"/>	
FAMILY HISTORY OF BREAST CANCER	<u>YES</u> <input type="radio"/> <u>NO</u> <input type="radio"/>	IF <u>YES</u> , MATERNAL <input type="radio"/> PATERNAL <input type="radio"/>	

PAIN:

PAIN EVALUATION	Using the pain chart below, please indicate your level of pain : _____
	Location of pain: _____
	Is pain (check one) : <input type="radio"/> Constant <input type="radio"/> Intermittent <input type="radio"/> Shooting <input type="radio"/> Throbbing <input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Other: _____

Wong-Baker FACES Pain Rating Scale



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Nurse Initials _____

Patient Name: _____ DOB: _____ Patient Number: _____

FALL RISK EVALUATION:

I HAVE FALLEN IN THE PAST YEAR.	YES: <input type="radio"/> 2 PTS	NO: <input type="radio"/>
I USE OR HAVE BEEN ADVISED TO USE A CANE OR WALKER.	YES: <input type="radio"/> 2 PTS	NO: <input type="radio"/>
SOMETIMES I FEEL UNSTEADY WHEN I AM WALKING	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I STEADY MYSELF BY HOLDING ONTO FURNITURE @ HOME.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I AM WORRIED ABOUT FALLING	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I NEED TO PUSH WITH MY HANDS TO STAND UP FROM A CHAIR.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I HAVE SOME TROUBLE STEPPING UP ONTO A CURB	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I OFTEN HAVE TO RUSH TO THE TOILET.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I HAVE LOST SOME FEELING IN MY FEET.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I TAKE MEDICINE THAT MAKES ME FEEL LIGHT-HEADED/TIRED	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I TAKE MEDICINE TO HELP ME SLEEP OR IMPROVE MY MOOD.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>
I OFTEN FEEL SAD OR DEPRESSED.	YES: <input type="radio"/> 1 PT	NO: <input type="radio"/>

TOTAL SCORE: _____ (7 OR MORE PTS = FALL RISK)

ADVANCED DIRECTIVES ****If YES, please bring copy of document(s) to your first appointment****

DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE / MEDICAL POWER OF ATTORNEY DOCUMENT?	YES: <input type="radio"/>	NO: <input type="radio"/>
DO YOU HAVE A <u>DNR (Do Not Resuscitate) ORDER</u> ?	YES: <input type="radio"/>	NO: <input type="radio"/>
DO YOU HAVE A <u>LIVING WILL</u> ?	YES: <input type="radio"/>	NO: <input type="radio"/>
WOULD YOU LIKE TO MEET WITH OUR ADVANCED CARE PLANNING FACILITATOR?	YES: <input type="radio"/>	NO: <input type="radio"/>

PATIENT SIGNATURE: _____

NURSE SIGNATURE: _____

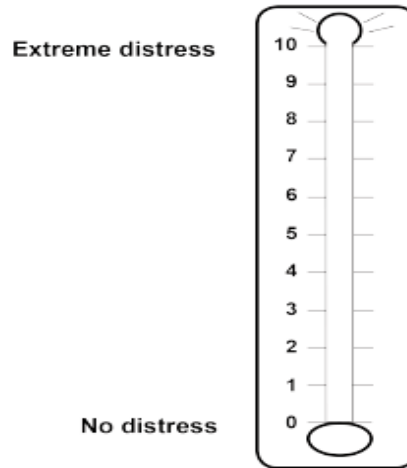
DOCTOR SIGNATURE: _____

DATE: _____

DISTRESS MANAGEMENT

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 below thermometer and circle the number you feel best describes the amount of distress you have been experiencing recently.



Second, review the checklist below. Please check if any of these items have been a concern for you.

PRACTICAL CONCERNS WITH:	FAMILY CONCERNS WITH:	EMOTIONAL CONCERNS WITH:	RELIGIOUS/ SPIRITUAL CONCERNS
<input type="checkbox"/> CHILD CARE	<input type="checkbox"/> CHILDREN	<input type="checkbox"/> FEAR	<input type="checkbox"/>
<input type="checkbox"/> HOUSING	<input type="checkbox"/> PARTNER	<input type="checkbox"/> NERVOUSNESS	
<input type="checkbox"/> INSURANCE/FINANCIAL	<input type="checkbox"/> CAREGIVER	<input type="checkbox"/> SADNESS	
<input type="checkbox"/> TRANSPORTATION	<input type="checkbox"/> HEALTH ISSUES	<input type="checkbox"/> WORRY	
<input type="checkbox"/> TREATMENT DECISIONS			
<input type="checkbox"/> WORK/SCHOOL			

Over the last 2 weeks, how often have you been bothered by the following problems:

1. Little interest or pleasure in doing things?
 Not at all Several days More than half the days Nearly every day

2. Feeling down, depressed or hopeless?
 Not at all Several days More than half the days Nearly every day

Other comments or concerns?

If you have any questions or would like to talk with one of our social workers as soon as possible, **please let us know during your visit TODAY**. Otherwise, you will be contacted by our social worker who routinely reviews the thermometer and is here to address your concerns at a later date.

Amy K Roberts, LCSW (352-732-0277) Wendy Hall, LCSW (352-527-0106)