ROBERT BOISSONEAULT ONCOLOGY INSTITUTE

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

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	Treatment Information Requested
Office and/or clinic notes – History and Physical	Tumor dose – Daily fractions
Pathology reports – Operative reports	Total treatment time – Total treatment dates
Discharge Summary – Laboratory data	Energy used – Distance – Filtration
Radiology Reports	Port drawings or films
ALL X-RAY 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: _____
_____ ,
Home Phone: _____
Social Security #: _____

Physician Information	
Referring Physician:	
Primary Physician:	
Other Physicians:	

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: _____

ROBERT BOISSONEAULT ONCOLOGY INSTITUTE

For Office Use Only:

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

PATIENT MEDICAL HISTORY FORM:

PATIENT NAME:		DOB:	
GENDER: MALE ◯ FEMALE ◯	PACEMAKER/DEFIBRILLATOR NO ◯ YES ◯ : INSERTION DATE / /		
CLAUSTROPHOBIC: NO ◯ YES ◯		CHEMO PORT: NO ◯ YES ◯	
PNEUMONIA VACCINE: NO ◯ YES ◯ : Date / /		FLU VACCINE: NO ◯ YES ◯ : Date / /	
COVID VACCINE: NO ◯ YES ◯ : Date / /		MODERNA ◯ PFIZER ◯ J&J ◯	
CITY & STATE OF BIRTH:		OCCUPATION:	

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

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

CONDITION(S) EXPERIENCED IN THE LAST MONTH (check ◯ for YES)		
◯ WEIGHT LOSS	◯ CHEST PAIN WITH EXERTION	◯ PAIN WHEN URINATING
◯ FEVERS	◯ ARM OR LEG SWELLING	◯ HEADACHES
◯ CHILLS	◯ DIFFICULTY SWALLOWING	◯ SEIZURES
◯ SKIN RASH / ITCHING	◯ FREQUENT INDIGESTION	◯ BALANCE/DEXTERITY LOSS
◯ VISION CHANGES:LOSS/BLURRED/DOUBLE VISION	◯ NAUSEA	◯ DIZZINESS
◯ HEARING LOSS	◯ VOMITING	◯ ARM OR LEG NUMBNESS
◯ SORES IN MOUTH / LIP	◯ DIARRHEA	◯ ARM OR LEG PARALYSIS
◯ HOARSENESS/VOICE CHANGE	◯ CONSTIPATION	◯ DEPRESSION
◯ SPITTING UP BLOOD	◯ JAUNDICE	◯ ANXIETY
◯ COUGH	◯ RECTAL BLEEDING	◯ EASY BRUISING OR BLEEDING
◯ SHORTNESS OF BREATH	◯ BLOOD IN URINE	◯ MUSCLE PAIN OR SWELLING

Nurse Initials____

Patient Name: _____**DOB:**_____ **Patient Number:**_____

COLORECTAL SCREENING:	**FECAL OCCULT BLOOD TEST: NO ◯ YES ◯ : Date / /**
	FIT DNA TEST (ex. Cologuard): NO ◯ YES ◯ : Date / /
	FLEXIBLE SIGMOIDOSCOPY: NO ◯ YES ◯ : Date / /
	CT COLONOGRAPHY: NO ◯ YES ◯ : Date / /
	COLONOSCOPY: NO ◯ YES ◯ : Date / /

FOR MEN: (check ◯ for Yes)	◯ **DECREASE IN SIZE OR FORCE OF URINE STREAM**	◯ **DIFFICULTY W/ SEX OR IMPOTENCE**
	PSA TEST: NO ◯ YES ◯ Date: / /	**BONE SCAN: NO ◯ YES ◯ Date: / /**
	HORMONE REPLACEMENT THERAPY: NO ◯ YES ◯ -DATES&DRUG NAME:	

FOR WOMEN (GYNECOLOGICAL HISTORY):			
CHANCE OF PREGNANCY: NO ◯ YES ◯		**# PREGNANCIES:**	
AGE @ 1ST PREGNANCY:		**# LIVE BIRTHS:**	
BREAST FEED: NO ◯ YES ◯		**AGE @ 1ST MENSTRUATION:**	
AGE @ MENOPAUSE:	**BIRTH CONTROL: NO ◯ YES ◯ -DATES&DRUG NAME:**		
HORMONE REPLACEMENT THERAPY: NO ◯ YES ◯ -DATES&DRUG NAME:			
MAMMOGRAM: NO ◯ YES ◯		**IF YES, DATE OF LAST MAMMOGRAM : / /**	
PAP SMEAR: NO ◯ YES ◯		**IF YES, DATE OF LAST PAP SMEAR : / /**	
HPV TESTING: NO ◯ YES ◯		**IF YES, DATE OF HPV TESTING : / /**	
CONDITIONS (check ◯ for Yes)	◯ **LUMP, DISCHARGE OR BREAST PAIN**	◯ **IRREGULAR MENSTRUAL BLEEDING**	
	◯ **IRREGULAR VAGINAL DISCHARGE**	◯ **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

Nurse Initials____

Patient Name: _____DOB:_____ Patient Number:_____

RECENT TESTS OR HOSPITILIZATIONS (INCLUDE DATES):

SURGERIES:

TYPE OF SURGERY	DATE	HOSPITAL	REASON FOR SURGERY

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

Nurse Initials____

Patient Name: _____DOB:_____ Patient Number:_____

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 #

TOBACCO USE:

SMOKING STATUS : ◯ Current Every Day Smoker ◯ Former Smoker ◯ Current Some Day Smoker ◯ Never	
# OF CIGARETTES PER DAY : ◯ Light Smoker ◯ 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? YES ◯ NO ◯ IF YES, TYPE:_____	# BOTTLES/GLASSES PER DAY: _____ # 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			

Nurse Initials____

Patient Name: _____DOB:_____ Patient Number:_____

FAMILY HISTORY OF PROSTATE CANCER	**YES ◯ NO ◯**	**IF YES , MATERNAL ◯ PATERNAL ◯**
FAMILY HISTORY OF BREAST CANCER	**YES ◯ NO ◯**	**IF YES , MATERNAL ◯ PATERNAL ◯**

PAIN:

PAIN EVALUATION	Using the pain chart below, please indicate your **level of pain : _____**
	Location of pain:
	Is pain (check one) : **◯ Constant ◯ Intermittent ◯ Shooting ◯ Throbbing** **◯ Dull ◯ Sharp ◯ Burning ◯ 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.

FALL RISK EVALUATION:

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

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

Nurse Initials____

Patient Name: _____DOB:_____ Patient Number:_____

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: ◯**	**NO: ◯**
DO YOU HAVE A DNR (Do Not Resuscitate) ORDER?	**YES: ◯**	**NO: ◯**
DO YOU HAVE A LIVING WILL?	**YES: ◯**	**NO: ◯**
WOULD YOU LIKE TO MEET WITH OUR ADVANCED CARE PLANNING FACILITATOR?	**YES: ◯**	**NO: ◯**

PATIENT SIGNATURE:_____

NURSE SIGNATURE:_____

DOCTOR SIGNATURE:_____

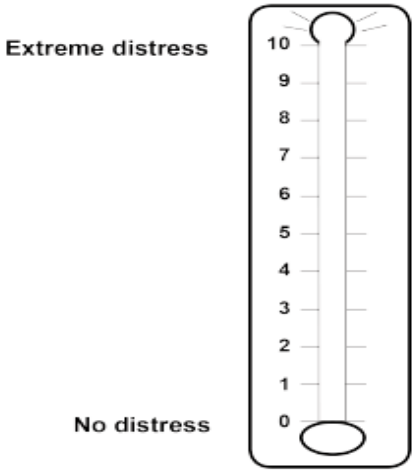
DATE: _____

Patient Name: _____DOB:_____ Patient Number:_____

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 conerns 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
◯ CHILD CARE	◯ CHILDREN	◯ FEAR	◯
◯ HOUSING	◯ PARTNER	◯ NERVOUSNESS	
◯ INSURANCE/FINANCIAL	◯ CAREGIVER	◯ SADNESS	
◯ TRANSPORTATION	◯ HEALTH ISSUES	◯ WORRY	
◯ TREATMENT DECISIONS			
◯ 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)

ATTENTION CASH PAY AND OUT OF NETWORK PATIENTS!

YOU HAVE THE RIGHT TO RECEIVE A
"GOOD FAITH ESTIMATE"
EXPLAINING HOW MUCH YOUR HEALTH CARE WILL COST

Under the law, health care providers are required to give cash pay and out of network patients an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, laboratory tests, and equipment fees.

- If you schedule a health care item or service at least 3 business days in advance, make sure your healthcare provider gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any healthcare provider for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider gives you a Good Faith Estimate in writing within 3 business days after you ask.

- If you receive a bill that is at least $400 or more for any provider than your Good Faith Estimate from that provider, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.