MEMORIAL OFFICE
9230 Katy Freeway, Suite 410
Houston, TX 77055
P: 281-556-6622 F: 281-647-7767

KATY OFFICE
18400 Katy Freeway, Suite 320
Houston, TX 77094
P: 281-647-7766 F: 281-647-7767

www.PremierOncology.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last) ☐ Male ☐ Female Gender

Date of Birth (MM/DD/YYYY) | Social Security Number | Driver License Number

Nationality (if not US National / Perm. Resident) | Ethnicity | Primary Language

Residential Address (Street address, City, State and Zip Code)

Mailing Address (if different than Residential Address)

Cell Phone | Home Phone
Can we leave message at home? ☐ Yes ☐ No | Work Phone
Can we to leave message at work? ☐ Yes ☐ No

Email Address

Marital Status | Number of Children | Children's Ages

Care Arrangement (who lives with you or helps you at home)

EMERGENCY CONTACT PERSON

Name | Relationship with patient | Phone

PRIMARY CARE PHYSICIAN

Practice Name | Practice Address

Your Physician Name | Phone | Fax

PHARMACY

Local Pharmacy: Name and Address | Phone

Mail Order Pharmacy: Name and Address | Phone

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INSURANCE INFORMATION

Primary Insurance _____ Subscriber Number _____ Group Number _____

Secondary Insurance _____ Subscriber Number _____ Group Number _____

POLICYHOLDER INFORMATION

Patient Name (First, Middle Initial, Last) _____ ☐ Male ☐ Female Gender

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Driver License Number _____

InsurancePlan Name / Type _____ Subscriber Number _____ Group Number _____

GUARANTOR (PERSON RESPONSIBLE FOR PAYING FOR MEDICAL SERICES)

Name (First, Middle Initial, Last) _____

Address (Street address, City, State and Zip Code) _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Driver License Number _____

WORK INFORMATION

☐ Working [FT ☐ / PT ☐] ☐ Student [FT ☐ / PT ☐] ☐ Domestic Engineer ☐ Retired ☐ Disabled ☐ Unemployed

Your current occupation _____ Physically Demanding: ☐ Yes ☐ No How many hours a day? _____

Name & Address of Employer/Organization _____

Supervisor Name _____ Phone _____ Fax _____

Do you use (or have ever used in the past) any of the following:

Alcohol: ☐ Yes ☐ No Tobacco: ☐ Yes ☐ No Recreational Drugs: ☐ Yes ☐ No
Sunscreen: ☐ Yes ☐ No Caffeine: ☐ Yes ☐ No

If yes, please provide details like how much, how often. If you have quit, when

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PERSON HAVING ACCESS TO PATIENT'S MEDICAL RECORD

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

Have you ever executed any of these:

Medical Power of Attorney	☐ Yes ☐ No
Directive to Physicians (Living Will)	☐ Yes ☐ No
Out-of-Hospital Do Not Resuscitate form	☐ Yes ☐ No

Please Note: If you have signed any of the above documents then provide a copy.

MEDICAL AND SURGICAL HISTORY

MEDICAL HISTORY		SURGICAL HISTORY	
DIAGNOSIS	**DATE**	**SURGERY TYPE**	**DATE**

FAMILY MEDIAL HISTORY (IS THERE ANY FAMILY HISTORY OF CANCER, BLOOD DISORDERS):

RELATIONSHIP TO PATIENT	AGE AT DIAGNOSIS	TYPE OF CANCER	STILL LIVING
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

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PREVENTIVE HEALTH MAINTENANCE

FEMALE	MALE
Do you do monthly self-exams for breast: ☐ Yes ☐ No	Do you do monthly self-exams for testicles: ☐ Yes ☐ No
Have you ever been trained properly for breast self-exam? ☐ Yes ☐ No	Have you ever been trained properly for testicular self-exam? ☐ Yes ☐ No
Please provide dates of: Last mammogram: _____ Last pneumonia vaccine: _____ Last colonoscopy: _____ Last bone density scan:	Please provide dates of: Last colonoscopy: _____ Last prostate exam: _____ Last PSA screening: _____ Last pneumonia vaccine: _____

CURRENT MEDICATIONS

Name of Medication	Dosage	How often taken	Taken for

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ALLERGIES FROM MEDICATION (PLEASE LIST ANY MEDICATIONS THAT YOU HAVE ADVERSE OR ALLERGIC REACTIONS TO)

Medication –Prescription / Over The Counter / Vitamin	Describe Reaction

REVIEW OF SYSTEMS

Breast

☐ Lump right breast ☐ Lump left breast ☐ Nipple discharge ☐ Nipple retraction ☐ Skin changes ☐ Other _____

Respiratory

☐ Shortness of breath ☐ Chest pain ☐ Chest congestion ☐ Cough ☐ Bloody sputum ☐ Asthma ☐ Other _____

Cardiology

☐ Dizziness ☐ Chest pain ☐ Palpitations ☐ Hypertension ☐ Leg edema ☐ Shortness of breath ☐ Other _____

Constitutional

☐ Weight gain ☐ Loss of appetite ☐ Fever ☐ Weakness ☐ Weight loss ☐ Fatigue ☐ Night sweats ☐ Pain

☐ Other _____

Endocrinology

☐ Sleep disturbances ☐ Cold intolerance ☐ Heat intolerance ☐ Diabetes ☐ Thyroid disease ☐ Other _____

ENT

☐ Cough ☐ Epistaxis ☐ Hearing loss ☐ Change in voice ☐ Sore throat ☐ Difficulty swallowing ☐ Vertigo ☐ Other _____

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REVIEW OF SYSTEMS - Continued

Hematology/Lymph

☐ Swollen glands ☐ Fatigue ☐ Loss of appetite ☐ Varicose veins ☐ Easy bruising ☐ Blood transfusion ☐ Anemia

☐ Other _____

Gastroenterology

☐ Blood in stool ☐ Diarrhea ☐ Vomiting ☐ Constipation ☐ Nausea ☐ Other _____

Female Reproductive

☐ Hot flashes ☐ Abnormal vaginal discharge ☐ Heavy periods ☐ Dyspareunia ☐ Dysmenorrhea ☐ Infertility

☐ Pelvic Pain ☐ Breast pain ☐ Frequent yeast infections ☐ Nipple discharge ☐ Breast pain ☐ Irregular periods

☐ Use of oral contraceptive ☐ Hormone replacement therapy ☐ Other _____

Male Reproductive

☐ Difficulty with erection ☐ Diminished sexual drive ☐ Penile discharge ☐ Incontinence ☐ Other _____

Neurology

☐ Headache ☐ Tingling numbness ☐ Seizures ☐ Insomnia ☐ Memory loss ☐ Dizziness ☐ Gait abnormality

☐ Other _____

Psychology

☐ Depression ☐ High stress level ☐ Sleep disturbances ☐ Suicidal ideation ☐ Eating disorder ☐ Anxiety

☐ Mental or physical abuse ☐ Schizophrenia ☐ Other _____

Urology

☐ Difficulty urinating ☐ Blood in urine ☐ Frequent urination ☐ Urinary incontinence ☐ Voiding dysfunction

☐ Nocturia ☐ Kidney stone ☐ Other _____

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MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and release information to that pay or if they require it for the proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card_____Date: _____

SUPPLEMENTAL POLICY

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on "Medigap" Card_____Date: _____

Consent for Treatment

I voluntarily give my permission to the healthcare providers of Premier Oncology Consultants to provide medical services to me, including any procedures like bone marrow, biopsy and aspiration. I understand that by signing this form, I am authorizing them to treat me for as long as I seek care from Premier Oncology Consultants, or until I withdraw my consent in writing.

Patient Name	Signature	Date

If this form has been completed by a person with legal authority to act on patient's behalf, such as parent, legal guardian, legal representative or a health care agent, please complete the following:

Name	Signature & Date	Relationship with patient

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ASSIGNMENT OF BENEFITS

I hereby authorize and request that payment of benefits by my insurance company(ies) be made directly to PREMIER ONCOLOGY CONSULTANTS, P.A. for services furnished to me or my dependents. I authorize PREMIER ONCOLOGY CONSULTANTS, P.A. to collect payments directly from insurance companies and to deposit checks received on my account when made out in my name.

I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by my insurance.

In addition, I authorize PREMIER ONCOLOGY CONSULTANTS, P.A. to disclose any and all information to my insurance company(ies) and/or their designated representatives. Such disclosure shall be for reimbursement purposes for the services received. I hereby release PREMIER ONCOLOGY CONSULTANTS, P.A. its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to my insurance company(ies) or their designated representatives.

I understand that PREMIER ONCOLOGY CONSULTANTS, P.A. is acting out of courtesy in filing for insurance benefits assigned to it and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s). I agree to participate and assist PREMIER ONCOLOGY CONSULTANTS, P.A. or its designated representatives with any appeal process necessary to collect payments for services rendered.

I understand that this assignment and authorization is subject to revocation at anytime, except to the extent that action has been taken in reliance thereof.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

I have read and fully understood the terms of this assignment and release, and I accept full responsibility for payment of all charges related to my care.

Patient Name	Signature	Date

If this form has been completed by a person with legal authority to act on patient's behalf, such as parent, legal guardian, legal representative or a health care agent, please complete the following:

Name	Signature & Date	Relationship to patient

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FINANCIAL AGREEMENT

This is a legally binding contract between PREMIER ONCOLOGY CONSULTANTS, P.A. (hereinafter, referred to as "Premier Oncology") and the patient. The words, *I, me, my, you and your* all refer to the patient.

READ & INITIAL ACKNOWLEDGEMENT OF EACH PARAGRAPH ON BLANK SPACE PROVIDED BELOW:

_____ **1. Insurance.** Premier Oncology participates in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing and understanding your insurance benefits is your responsibility**. Premier Oncology shall and is not responsible for filing your insurance claim, but as a courtesy we will do so. Please contact your insurance company with any questions you may have regarding your coverage. Current insurance cards must be presented at every office visit. You will have to pay the remaining balance after insurance company payment immediately upon receipt of a statement from a Premier Oncology Consultants.

_____ **2. Insurance documentation.** Before seeing the doctor, you must complete our patient registration form and provide copies of your driver's license, current insurance cards, referral documents from other providers and other relevant information about your primary and secondary insurance benefits including. If you fail to give complete and accurate information about your insurance benefits in a timely manner this may result in delay or denial of your claim, and you may be responsible for entire cost of service.

_____ **3. Claims submission.** As **a courtesy Premier Oncology will submit your claims and assist you in getting your claims paid.** Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. ***Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are NOT party to that contract.***

_____ **4. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____ **5. Payment.** You will have to pay Premier Oncology the balance on your account after your insurance claim has been processed. If your insurance benefit requires you to provide a referral and if the referral is not in place before your appointment, then you will have to pay an estimate of charges for your visit or treatment in advance.

_____ **6. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud.** Please help us in upholding the law by making your required payment at each visit. In case you have a high deductible policy or do not currently have insurance benefits, you will have to pay an estimate of charges for your visit or treatment in advance and understand that other charges may also apply.

_____ **7. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

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FINANCIAL AGREEMENT (Continued)

_____ **8. Necessary services.** All services provided to you by Premier Oncology are on the basis of medical necessity. If you fail to have a procedure performed or do not comply with the provider's instructions it may be against medical advice and may void your insurance benefits. Should this occur, you will be liable to pay the full balance on your account after insurance has been processed.

_____ **9. Nonpayment.** If your account is over 30 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if your account becomes delinquent, we may refer your account to a collection agency, a delinquency fee of $50 will be added to your account and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. In case your account is referred to collection, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs and attorney fees. Please communicate with our billing staff to inform them if you know your payment will be late in arriving or if payment arrangements are needed.

_____ **10. Missed appointments.** Premier Oncology charges for $50.00 for missed or cancelled office visits in which at least 24-hour notice was not given. Also, there will be a $35.00 fee for all returned checks. These charges shall solely be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

_____ **11. Credit Card Policy.** Please review and complete our Credit Card on File Policy form in order to avoid any additional fees associated with your account balance.

I have read and fully understood the contents of this financial agreement and I accept full responsibility for payment of all charges related to my care.

Patient Name	Signature	Date

If this form has been completed by a person with legal authority to act on patient's behalf, such as parent, legal guardian, legal representative or a health care agent, please complete the following:

Name	Signature & Date	Relationship to patient

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CREDIT CARD ON FILE POLICY

At Premier Oncology Consultant, PA. we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $5.00 will be added to your account for any additional statements after we mail the first statement.

Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I _____, authorize Premier Oncology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number: _____

Expiration Date: _____ / _____ / _____

CVV Code: _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

I (we), the undersigned, authorize and request Premier Oncology Consultants, PA. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me by Premier Oncology Consultants, PA.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Premier Oncology Consultants, PA. in writing and the account must be in good standing.
Patient Name (Print): _____

Patient Signature: _____

Date: _____

PREMIER Oncology CONSULTANTS

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ hereby authorize the following Physician / Hospital / Laboratory / Therapy or Imaging Facilities:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

ATTN: _____

To disclose and release complete health record including, but not limited to, diagnoses, lab test / results, radiology, pathology, treatment plan, and billing records for all conditions of myself, release to:

☐ *Dr. Shagufta Naqvi*
☐ *Dr. Mohammad Riaz*
PREMIER ONCOLOGY CONSULTANTS
9230 KATY FREEWAY, SUITE 410
SPRING VALLEY MEDICAL PLAZA
HOUSTON, TEXAS 77055
PHONE: 281-556-6622 (MAIN)
FAX: 281-647-7767 (CENTRAL)

☐ *Dr. Shagufta Naqvi*
☐ *Dr. Mohammad Riaz*
PREMIER ONCOLOGY CONSULTANTS
18400 KATY FREEWAY, SUITE 320
HOUSTON METHODIST WEST- BLDG #1
HOUSTON, TEXAS 77094
PHONE: 281-647-7766 (KATY)
FAX: 281-647-7767 (CENTRAL)

Records Requested:

_____

_____

_____

The information may be released or disclosed in printed and/or digital format. A photocopy of this assignment is to be considered as valid as the original until revoked in writing.

_____ _____
Print: Patients / Representative Name Patients DOB

_____ _____
Signs: Patients / Representative Signature Date

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MEDICAL INFORMATION RELEASE AUTHORIZATION - (HIPPA)

Patient Name: _____ DOB: _____

I hereby authorize Premier Oncology Consultants, PA. to release information regarding my protected health information to the following persons and/or agency. I also give my permission to Premier Oncology Consultants, PA. to communicate information regarding my appointment time or any possible changes to my scheduled appointment to the persons listed below.

Emergency Contact: (Individual we will call should you have an emergency such as a sudden injury or illness while in our care.)

(Emergency Contact / HIPAA)	(Relationship)	(Phone – Required)

☐ By checking this box, I do NOT authorize the release of my HIPAA information to my Emergency Contact.

Additional HIPAA Authorizations:

Name:	Relationship:	Phone (optional):

Premier Oncology Consultants, PA. may contact me personally:

Messages May Be Left At These Numbers: ☐ Cell ☐ Home ☐ Work

Patient Information

I have the right to revoke this authorization at any time by notifying Premier Oncology Consultants, PA. in writing. This authorization will not expire until then. The revocation will not apply to information that has already been released in response to this authorization. Information obtained by individuals on this authorization may be subject to redisclosure by the recipient(s).

Signature: _____ **Date:** _____

****If Signed by a Legal Representative, Relationship to Patient:** _____