Miami Hematology and Oncology Associates

151 NW 11 ST | E-304 | Homestead, FL 33030 Phone: 786-504-3084 Fax: 786-504-3086

Today's Date/Fecha de hoy:	☐ Male	☐ Female
Name/Nombre:	SS#:	DOB/Fecha de nacimiento:
Address/Direccion:	Phone number/Numero Telefonico:	
Mailing Address (if differeny from above)/ Otra direccion:		
Employer/Empleo:	Occupation/Ocupacion:	
Unemployed/Desempleado: ☐ Reason/Rason:	☐ Rerited/Retirado	
Referring Physician/Medico Referente:	Primary Physician/Doctor Primario:	
Reason for referral/Rason per referido:		
Other Physicians involved in your care/Otros Doctores relacionados con su salud:		
Marital Status/Estado civil: Married/Casado ☐ Single/Soltero ☐ Divorced/Divorciado ☐ Widowed/Viudo ☐		
Spouse's Name/Nombre de esposo/a:	DOB/Fecha de nacimiento:	
Spouse's Telephone/Numero de telefono de pareja:		
Emergency Contact/Contacto de Emergencia:	Phone number/Numero Telefonico:	
Emergency contact's address/Direccion de contacto de emergencia:		

Do you have a Durable Power of Health Care (DPAHC), Advance Directive or POLST?
Usted tiene algun documento que indique otra persona responsible y decidir por su salud?

☐ Yes **(Please bring copy),** Si **(Favor de traer copia)** ☐ No

Please list anyone (family members, caregiver, or friend) and relationship to the person(s) with whom you will permit our Physician and staff to discuss your medical condition(s).

Por favor indique cualquier persona (familiares, cuidadores o amigos) y su relación con la (s) persona (s) con las que le permitirá a nuestro médico y al personal hablar sobre su (s) condición (es) médica (s).

Do you feel safe in you home?/ Usted se siente seguro en su casa?

☐ Yes ☐ No, please explain/favor de explicar:

Do you have any religious/spiritual cultural preferences?/ Usted tiene alguna preferencia religiosa or espiritual?

☐ Yes, please explain/favor de explicar: ☐ No

Do any of your beliefs change how we need to provide your care?/ Alguna de sus creencias cambiaria la forma en que tenemos que proporsionar su salud?

☐ Yes, please explain/favor de explicar: ☐ No

Do you feel you have an adequate support system in place?/ Usted se siente que tenga un sistema de apoyo adecuado?

☐ Yes ☐ No, please explain/favor de explicar:

Do you have any pain?/ Usted tiene algun dolor? ☐ Yes/Si ☐ No

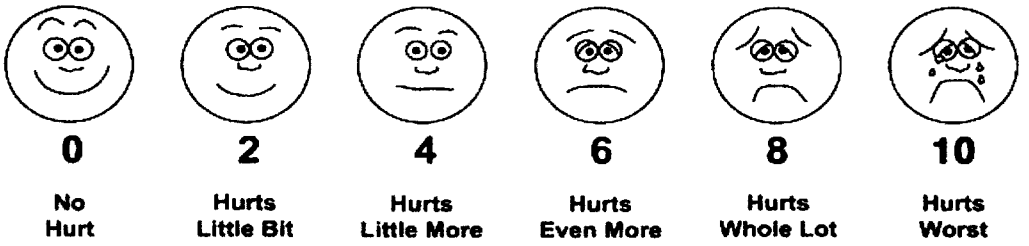
Where is the pain?/Donde es el dolor? Please describe/ Favor de esplicar:	When did the pain start? Cuando comenso el dolor?

What makes the pain better or worse?/ Que hace mejorar o empeorar el dolor?

Are you currently taking pain medication? Esta tomando medicina para el dolor?

☐ Yes ☐ No

Please rate your pain/ Porfavor elija el nivel de su dolor:



Past Medical History/ Historial Medico

Have you had any of the following conditions? Usted a tenido algunos de los ciguientes?

Heart Disease/ Enfermedad de corazon	
Heat attack/ Infarto	
High Blood Pressure/ Precion Alta	
High Cholesterol/ Cholesterol Alto	
History of blood clots/ Historial de cuagulos	
Emphysema/ Emfesima	
Asthma/ Asma	
Seizures/ Convulsiones	
Kidney Disease/ Enfermedad de Renones	
Cirrhosis of Liver/ Cirrosis del Igado	
Hepatitis	
Diabetes	
Thyroid Problems/ Problema de tiroide	
Ulcers or colitis/ Ulceras o colitis	
Lupus or Scleroderma/ Esclerodermia	
Bleeding Problems/ Problema de sangrado	
Phychiatric Problems/ Problema psiquiatricos	
Infectious Disease/ Enfermedades infecciosas	
Previous Cancer/ Cancer anterior	
Other/ Otro:	
Other/ Otro:	

Past Surgical History/ Historia quirúrgica pasada

Have you had any of the following operations? Usted a tenido algunos de los ciguientes procedimientos?

Heary Bypass/ Bypass del corazon	
Defibrillator Placed/ Desfibrilador	
Pacemake Placed/ Marcapasos	
Lung/ Pulmon	
Breast Biopsy/ Biopsia del Ceno	
Breast Lumpectomy/ Tumorectomia	
Matectomy/ Mastectomia	
Stomach/ Estomago	
Colon/Rectum/Anus	
Hysterectomy/ Histerectomia	
Angioplasty or stents	
Other/ Otro:	
Other/ Otro:	
Other/ Otro:	

Review of symptoms/ Revisión de Síntomas

Do you now, or have you recently had any of the following? ¿Ahora, o ha tenido recientemente alguno de los siguientes?

General	
Loss of Appetite/ Perdida de apetito	
Weight loss/ Perdida de peso	
If yes, how many pounds? Si, cuantas libras?	
Unexplained fever/ Fiebre inexplicable	
Drenching Night Sweats/ Sudor en la noche	
ENT	
Diffuculty Hearing/ Dificultad en escuchar	
Do you wear dentures?/ Usted usa dentaduras?	
Do they fit well? Te quedan comodas?	☐ Yes/Si ☐ No
Painful swallowing and/or Sore Throat/ Dolor tragando or de garganta?	
Sores in mouth/ Llagas en la boca	
Cardiovascular	
Chest pain/ Dolor en el pecho	
Irregular pulse/ Pulso irregular	
Ankle Swelling/ Hinchazon de los tobillos	
Shortness of breath lying flat/ Falta de aliento	
Genitourinary/Genitourinario	
Painful urination/ Dolor en orinar	
Frequent urination at night/ Orinar frequente de noche	
Slow urinary stream/ Orina despacio	
Blood in urine/ Sangre en la orina	
Neurogical	
Headache/ Dolor de cabeza	
Double or blurred vision/ Vision doble or borroso	
Poor balance/ Poco balance	
Seizures/ Convulsiones	
Weakness of arm or leg/ Debilidad en las piernas or brasos	
Numbness or tingling/ Endumecimiento or hormigueo	
Dizziness or lighheaded/ Mareos o aturdimiento	
Respiratory	
Cough without sputum/ Toz sin secreciones	
Cough with sputum/ Toz con secreciones	
Coughing up blood/ Toz con sangre	
Shortness of breath with exertion/ Perdidad de aliento con esfuerzo	

Gastrointestinal	
Difficulty swallowing/ Dificultad en tragar	
Heartburn/ Acidez	
Frequent Nausea/ Naucias frecuentes	
Vomitting/ Vomitos	
Diarrhea/ Diarrea	
Black stool/ Heces de color negro	
Bloody stool/ Heces con sangre	
Date of last bowel movement/Fecha de ultimo heces:	

Phychiatric	
Trouble sleeping/ Problema en dormir	
Anxiety/ Anciedad	
Depression/ Depresion	
Feeling of worthlessness/ Se siente inutil	
Suicidal thoughts/ Pensamiento de suicidio	

Hematologic	
Bleed or bruise easily/ Sangrar o magullar fácilmente	

What is the problem you need us to address the most?/ Cual es el problema que quiziera aderijir?
What concerns do you have about your illness and/or treatment?/ Qué preocupaciones tiene sobre su enfermedad y / o tratamiento?

Family History of Cancer / Historia familiar del cáncer

Please list your closest relatives who have had cancer/ Porfavor liste parientes mas cercanos que an tenido cancer.

Relationship/ Relacion	Type of cancer/ Tipo de cancer

Cancer Screening History/ Historial de detección de cáncer

Have you had any of the following?/ Usted a tenido alguno de los siguientes?

Colonoscopy/ Colonoscopia	
Men: Portate exam/ Examen de prostata	
Women: Pelvic Exam, Pap smear/ Papanicolaou	
Mammogram and Breast Exam/ Mamograma or examen	

Previous Chemotherapy/ Quimioterapia Anterior ☐ Yes/Si ☐ No

Start Date Fecha de comienzo	End Date Fecha final	Drugs Used Medicinas usadas	Treatment Facility and Dr. Lugar de tratamiento y Dr.

Previous Radiation Treatment/ Tratamiento de Radiacion Anterior ☐ Yes/Si ☐ No

Start Date Fecha de comienzo	End Date Fecha final	Drugs Used Medicinas usadas	Treatment Facility and Dr. Lugar de tratamiento y Dr.

Allergies/Alergias

List drug type and reaction/ Porfavor describa tipo de medicina y reaccion

Drug/Medicina	Reaction/Reaccion

Habits/ Habitos

Have you ever smoked? (Include ciagarettes, cigar, pipe) ☐ Yes/Si ☐ No
Usted a fumado? (Cigarros, pipa, etc)

How manu packs a day? *Cuantos paquetes al dia?*		For how long? Por cuanto tiempo?	
Do you still smoke? Usted todavia fuma?	☐ Yes/Si ☐ No, quite date/ fecha que termino _____/_____/_____		

Would you like help to stop smoking? Quisiera usted ayuda para terminar de fumar?
☐ Yes/Si ☐ No

Do you drink alcohol? ☐ Yes/Si ☐ No
Usted bebe alcohol?

Do you still drink? Usted todavia bebe?	☐ Yes/Si ☐ No, quite date/ fecha que termino _____/_____/_____

How many drinks?/ Cuantas bebidas?
_____ days/dia _____ week/semanal

Would you like help to stop drinking?/ Quisiera usted ayuda para terminar de beber?
☐ Yes/Si ☐ No

Female Patient ONLY/ Mujeres SOLAMENTES			
Number of pregnancies? Numero de embarazos?		Number of life births? Numero de nacidos vivos?	

Last menstrual period/ Ultimo periodo? _____

Have you had any abnormal bleeding lately?/ Usted a tenido algun sangramiento abnormal?

☐ Yes/Si ☐ No

Have you gone through menopause?/ Usted ha llegado a la menopausia?

☐ Yes/Si ☐ No

If yes, at what age?/ A que edad? _____

Have you been on hormone replacement therapy, such as estrogen?
Usted a estado en terapia hormonal, come estrogeno?

☐ Yes/Si ☐ No

If yes, how many years?/ Por cuanto tiempo? _____

If you have not gone through menopause, are you or might you be pregnant?
Si usted no a tenido la menopausia, esta o puede estar hembarazada?

☐ Yes/Si ☐ No

If you have not gone through menopause, are you using some form of birth control?
Si usted no a tenido la menopausia, esta usando algun tipo de anticonceptivo?

☐ Yes/Si ☐ No

_____ _____

Signature/ Firma Date/Fecha

Patient Health Questionaire (PHQ-9)

Complete the screening by answering the following questions

Name: _____ Date of Visit: _____

Over the last 2 weeks, how often have you been bothered by any of the following problem? ***En las últimas 2 semanas, ¿con qué frecuencia le ha molestado alguno de los siguientes problemas?***	**Not at all** ***De ningún modo***	**Several days** ***Varios dias***	**More than 1/2 the days** ***Más de la mitad de los días.***	**Nearly every day** ***Casi todos los dias***
1. Little interest or pleasure in doing things. *Poco interés o placer en hacer las cosas.*	0	1	2	3
2. Feeling down , depressed, or hopeless. *Sintiendose decaido(a), deprimido(a) o sin esperanza.*	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much *Tiene dificultad para dormir, mantenerse dormido o duerme demasiado*	0	1	2	3
4. Feeling tired or having little energy. *Sintiendose cansado o tener poca energía.*	0	1	2	3
5. Poor appetite or overeating. *Pobre apetito o comer en exceso*	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down. *Se siente mal consigo mismo, o siente usted es un fracaso o que ha quedado mal con usted mismo(a) o con su familia*	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television. *Tiene dificultad en concentrarse en cosas, tales como leer el periódico o mirar televisión.*	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual. *Se mueve o hablar tan lento, que otras personas podrían notarlo? O por lo contrario- muy inquieto(a) o agitado o ha esta movidose mucho más de lo normal.*	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way. *Pensamientos de que usted estarías mejor muerto(a) o de alguna manera lastimandose a usted mismo(a).*	0	1	2	3

Colum totals *(Totales de columnas)* _____ + _____ + _____

Add totals together *(Suma los totales juntos)* _____

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

Si marcó algún problema, ¿qué tan difícil han sido esos problemas para que usted pueda hacer su trabajo, cuidar las cosas en el hogar o llevarse bien con otras personas?

☐ Not difficult at all *No es difícil en absoluto*

☐ Somewhat difficult *Algo difícil*

☐ Very difficult *Muy difícil*

☐ Extremely difficult *Extremadamente difícil*

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUB Y COMFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with MIAMI HEMATOLOGY AND ONCOLOGY., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by Law.

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de MIAMI HEMATOLOGY AND ONCOLOGY., y doy mi consentimiento para usar y compartir Información Personal de Salud como lo permita y/o la ley.

Patient Name: *(Please print)* _____
Nombre del Paciente: *(Nombre en letra de molde por favor)*

Patient Signature: *(or legal representative; proof may be requested)* _____
Firma Del Paciente: *(o representante legal; prueba puede ser requerida)*

Date: *(dd/mm/yy)* _____
Fecha: *(dd/mm/aa)*

EMAIL/TEXT MESSAGE TO MOBILE NUMBER CONSENT FORM
CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJE DE TEXTO A MOVIL

Purpose: This form is used to obtain you consent to communicate with you by email/mobile text messaging regarding your Protected Health Information, **MIAMI HEMATOLOGY AND ONCOLOGY., (MHAO)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **MHAO** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, MHAO cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **MHAO** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Propósito: Este formulario se utiliza para obtener su consentimiento para comunicarse con usted por correo electrónico / mensaje de texto móvil con respecto a su Información de Salud Protegida, **MIAMI HEMATOLOGY AND ONCOLOGY. (MHAO)** ofrece a los pacientes la oportunidad de comunicarse por correo electrónico / mensajes de texto móviles. La transmisión de información del paciente por medio de mensajes de texto móviles tiene una serie de riesgos que los pacientes deben considerar antes de otorgar el consentimiento para utilizar el correo electrónico / mensajes de texto móviles para estos fines. **MHAO** utilizará medios razonables para proteger la seguridad y confidencialidad de la información enviada y recibida por correo electrónico / mensajes de texto móviles. Sin embargo, **MHAO** no puede garantizar la seguridad y confidencialidad de la comunicación por correo electrónico / mensajes de texto móviles y no será responsable por la divulgación inadvertida de información confidencial.

Yo reconozco que he leído y entiendo completamente este formulario de consentimiento. Entiendo los riesgos asociados con la comunicación de mensajes de texto por correo electrónico / móvil entre **MHAO** y yo, y acepto las condiciones que se detallan en este documento. Cualquier pregunta que pueda haber tenido fue respondida.

PATIENT ACKNOWLEDGE AND AGREEMENT/RECONOCIMIENTO Y ACUERDO DEL PACIENTE

My Consented Email Address is: _____
Mi dirección de correo electrónico autorizada es:

My Consented for Text Messaging to: _____
Mi consentimiento para enviar mensajes de texto a:

_____ _____
Patient Signature/Firma del Paciente Date/Fecha

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

Patient Name: _____ SSN: _____

Telephone #: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

OFFICE USE ONLY/ USO DE LA OFICINA SOLAMENTE

Name of Healthcare Facility from which records are requested: _____

Ph: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Dates of Treatment Requested: _____ Reason for Disclosure: _____

MAIL INFORMATION TO: **MIAMI HEMATOLOGY AND ONCOLOGY**
151 NW 11 Street, Suite No. E-304 Homestead, FL 33030

OR FAX TO: **786-504-3086**

I hereby authorize MIAMI HEMATOLOGY AND ONCOLOGY., to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, genetic testing information, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy notes. The release of Psychotherapy notes requires a separate authorization. Psychotherapy notes defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical records.

Check a box

	Complete Record		Radiology Reports
	Laboratory Reports		Pathology Reports
	Other (Specify)		

SPECIFIC AUTHORIZATIONS

The following information will not be release unless you specifically authorize it by marking the relevant box(es) below:

☐ Drug/Alcohol Abuse or Treatment ☐ HIV/AIDS Test Results or Diagnosis ☐ Genetic Testing Information

☐ Psychotherapy Notes (The release of Psychotherapy Notes requires a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken hereon. This authorization and consent will expire one year from the date authorization written below.
Your health care (or payment for care) will not be affected by whether you sign this authorization. Once your health care information is release, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____ / _____ / _____

Signature of Patient or Legal Representative

Printed Name: _____ Relationship, if not patient: _____

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: Parent signing for a patient under the age of 18.

*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the names individual. If the estate has not been probated, a death certificate is required coupled with documents naming the administrator or executor of the estate.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ SSN: _____

Telephone #: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

OFFICE USE ONLY/ USO DE LA OFICINA SOLAMENTE

I authorize **MIAMI HEMATOLOGY AND ONCOLOGY.**, to release the health information indicated below to:
Yo autorizo a MIAMI HEMATOLOGY AND ONCOLOGY., a proporcionar la información de salud como se indica a:

Person/Organization: _____
(Persona/Organización)

Address: _____
(Direccion)

Phone: _____ Dates of Medical Record Requested: _____
(Telefono) *(Fechas de expedientes médicos solicitados)*

Reason for Disclosure *(Proposito de entrega):*

_____ Continuing Care *(Cuidado continuo)* _____ Insurance *(Seguro)* _____ Legal *(Legal)* _____ Personal Use *(Uso Personal)* _____ Other Reason *(Otro Proposito)*

Check a Box

☐	Complete Record *(Record Completo)*	☐	Radiology Reports *(Reportes Radiologia)*
☐	Physical Therapy/Occupantional *(Terapia Fisica/Ocupacional)*	☐	Pathology Reports *(Reportes Patologia)*
☐	Lab Reports *(Informes de Laboratories)*	☐	EKGs
☐	Other *(Specify)* Otro *(Especifique)*	☐	Operative Report *(Reporte Operativo)*

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
(La siguiente información no puede ser revelada a menos que usted lo autorice específicamente marcando las casillas correspondientes a continuación):

☐ Drug/Alcohol Abuse or Treatment *(Abuso o Tratamiento de Droga/Alcohol)*

☐ HIV/AIDS Test Results or Diagnosis *(Resultados o Diagnostico VIH/CIDA)*

☐ Genetic Testing Information *(Información de Pruebas Genéticas)*

☐ Psychotherapy Notes (The release of Psychotherapy Notes requires a separate authorization)
(Notas de Psicoterapia (Revelar Notas de Psicoterapia requiere una autorización por separado)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.
(Este consentimiento está sujeto a revocación en cualquier momento, excepto en la medida en que se haya tomado acción al respecto. Esta autorización y consentimiento vencerán un año a partir de la fecha de autorización escrita a continuación.)

Your health care (or payment for care) will not be affected by whether you sign this authorization. Once your health care information is release, redisclosure of your health care information by the Recipient may no longer be protected by law.
(Su atención médica (o pago de la atención) no se verá afectada por la firma de esta autorización. Una vez que su información de atención médica sea divulgada, la divulgación de su información de atención médica por parte del Beneficiario puede dejar de estar protegida por la ley.)

_____ Date Signed: _____ / _____ / _____
Patient Signature or Legal Representative *(Firma del Paciente o Representante Legal)* *(Fecha)*

_____ Relationship, if not patient: _____
Print Name *(Nombre en Letra Molde)* *(Relacion si no es el paciente)*

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e court appointed guardian, durable power of attorney for health care).
* Si no es la firma del paciente, debe acompañar la solicitud una copia de la documentación legal que verifica al representante personal del paciente (es decir, un tutor designado por el tribunal, un poder notarial duradero para atención médica)

Miami Hematology and Oncology Associates
151 NW 11TH ST, Suite E-304
Homestead, FL 33030

Out of Pocket Costs & Deductibles

If you are about to undergo treatment, you should know that your out-of-pocket costs and deductibles will be reached for the year. This is due to the high cost of chemotherapy and other drugs associated with your treatment. In many instances, you will reach that figure the first day you sit in the chemo chair.

Therefore, for us to order these drugs, patients must:

- Be given an estimate of their bill before treatment.
- Pay the remainder of their out of pocket costs and deductibles before treatment is rendered.
- Meet with Patient Assistance to review assistance options, if available.

Please note, we are not a charitable organization, and therefore we cannot assume the debt our patients incur for treatment. Our vendors require payment upfront for their product, and therefore, we must request for payment upfront as well. Please keep this in mind before making your treatment decisions.

Si está a punto de someterse a un tratamiento, debe saber que sus costos de desembolso y deducibles se alcanzarán para el año. Esto se debe al alto costo de la quimioterapia y otros medicamentos asociados con su tratamiento. En muchos casos, llegará a esa cifra el primer día que se siente en la silla de quimioterapia.

Por lo tanto, para que ordenemos estos medicamentos, los pacientes deben:

- Recibir un estimado de su factura antes del tratamiento.
- Pagar el resto de sus costos de desembolso y deducibles antes de que se realice el tratamiento.
- Reunirse con Asistencia al Paciente para revisar las opciones de asistencia, si están disponibles.

Tenga en cuenta que no somos una organización caritativa y, por lo tanto, no podemos asumir la deuda que nuestros pacientes incurren para el tratamiento. Nuestros proveedores requieren el pago por adelantado de su producto y, por lo tanto, también debemos solicitar el pago por adelantado. Por favor, tenga esto en cuenta antes de tomar sus decisiones de tratamiento.

Regards,
Tony N. Talebi M.D.
Miami Hematology and Oncology Associates, LLC

_____

Patient Signature/Firma de paciente

Miami Hematology and Oncology Associates
151 NW 11TH ST, Suite E-304
Homestead, FL 33030

Patient Financial Policy

Thank you for choosing Miami Hematology and Oncology Associates as your healthcare provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

We request all patients to complete our Patient Information Form prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e address, name, insurance information, phone number, etc.). Our financial policy is as follows:

- Payment is due at the time of services rendered for all patients, unless you or your insurance company has made other arrangements in advance. For your convenience, we accept Personal Checks, Cash, Visa, Mastercard, American Express, and Discover.
- Medicare: We accept assignment on Medicare claims. If you have Medicare, you will be required to pay your 20% co-payment and deductible if it has not been met this yearly. Please provide us with any secondary insurance information you may have. Most secondary insurance will cover all Medicare allowable charges. If the secondary insurance does not cover the services provided, you will be responsible for the payment on your account.
- If your Physician is NOT a provider for your insurance company, as courtesy, we will file your claims for you if assign benefits to your Physician. If your insurance company does not pay within reasonable time, you will be responsible for the payment of your account.
- If your Physician is a provider with your insurance, we will file your claim, and you will be responsible for the deductible and co-payments at the time the services are rendered.
- **All balances must be paid in full before your office visit**. If you cannot pay your balance in fill, please speak with our Accounts Manager to discuss a possible payment arrangement. If the terms of your payment agreement are not met, you may be release from our care and your account may be sent to collections.
- **Outstanding Balances**- We urge you to keep your account current and paid in full. All account balances that are over **90 days past due** will be sent to an outside agency for collections. At that point, the account is out of our hands. If you need to make special arrangements, it is your responsibility to contact our Accounts Manager at our office before this step is taken.
- **Payment Arrangements**- Under special circumstances, payment arrangements may be made with our Accounts Manager. Is it the responsibility of the patient to keep this arrangement paid and current.
- **Returned Checks**- The charge for a returned check is $30 payable in cash or money order. This will be applied towards your balance in addition to any additional insufficient funds we incur. You may be placed on a "Cash only" basis following the returned check.
- **Medical Record Copied and FMLA Paperwork**- If you want a copy of your records, you will be charged $1 per page. There is a $50 fee for completion of FMLA paperwork. There is a $100 fee for letters written by Dr. Tony Talebi.
- **Failed Appointment Charge**- We reserve the right to charge for each failed appointment not cancelled at least 24 hours before the scheduled appointment time. **This charge is not covered by your insurance.**

I have read and agree to the Terms outlined above.

_____ _____

Patient Signature/Firma de paciente Date/Fecha

Miami Hematology and Oncology Associates
151 NW 11TH ST, Suite E-304
Homestead, FL 33030

Tony N. Talebi M.D.
Diplomate, American Board of Hematology/Oncology & Internal Medicine

Helpful suggestions from us to you:
We will review your imaging findings, lab results, outside reports, and I will when available, discuss with other health providers, discuss with family (if present) and you the patient regarding the treatment plan.

Other factors taken into consideration include:
Benefits and risks involved, patient wishes and symptoms and my recommendations
Discussion will be held with you the patient and family (if present) regarding the suggested treatment plans also be aware of the detriments of smoking and to quit smoking if currently smoking. We would also like to notify you that some medicines prescribed may potentially cause excessive bleeding (in the case of anticoagulants may cause intracerebral and GI bleed, as well as, fatal bleeding and some medicines do not have adequate reversal agents) or drowsiness and that opiate medicines may cause one to stop breathing.

If you ever experience chest pain, vague abdominal pain, fever, elevated or low Blood pressure, intractable vomiting, blood in stool or urine, dizziness, shortness of breath, sudden extremity swelling or redness, passing out or any other symptoms that are new or different to please visit the ER or discuss with your primary care physician or other specialists (cardiology, surgery, GI, Neurology, infectious disease, pulmonary..ect) as these symptoms may suggest a heart attack, stroke, pulmonary embolism, serious infection, kidney or liver failure, gastrointestinal bleed, seizure, progression of disease, high medicine levels in the body, internal bleeding.

Also, we suggest a proper low animal fat, high protein, low carbohydrate, organic earth based diet and exercise 30 minutes a day if tolerable.

We stressed to you the importance of following up on all of your tests results personally by calling our office or following up in person and that failure to follow up w their appointments will result in discharge from the practice. Patient and family (if present) have been advised that recording the conversation without prior consent and knowledge of Dr. Talebi or his staff is not permitted.

Patient is always encouraged to obtained second opinion regarding care received at this practice.

_____
Patient Signature

_____
Witness (Office use only)

Miami Hematolgy and Oncology Associates
151 NW 11 ST | E-304 | Homestead, FL 33030 Phone: 786-504-3084 Fax: 786-504-3086

List of Current Medications/ Lista de Medicamentos

Patient Name: _____ Date of Birth: _____
Pharmacy Name: _____ Pharmacy Address: _____
Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

List **ALL** tablets, patches, drops, and ointments. Include prescription, over the counter, herbal, vitamins, and diet supplement products. Also list any medicines you take occasionally (i.e. Viagra, Albuterol, Nitroclycerin, etc.).

Liste TODAS las tabletas, parches, gotas y ungüentos. Incluya productos recetados, de venta libre, a base de hierbas, vitaminas y suplementos dietéticos. También enumere los medicamentos que toma ocasionalmente (por ejemplo, Viagra, Albuterol, Nitroclycerin, etc.).

Medication (Brand & Generic)/ Medicamentos (Marca y Genéricos)	Dose/ Dosis	Frequency/ Frecuencia