TMH Physician Partners
CANCER & HEMATOLOGY SPECIALISTS

Welcome! On behalf of Tallahassee Memorial HealthCare, thank you for choosing us. We look forward to meeting and learning more about you during your first appointment.

In anticipation of your visit, we have included the following:

Welcome Letter
Patient Registration
Authorization and Agreement Form
Patient Profile
Verbal Communication Form
TMH Authorization for Release of Protected Health Information Form (highlighted areas only)
Medical Records release
TMH Cancer Center Stress Tetrameter

Please bring the included (completed) forms along with your current medications, insurance card(s), and a valid photo ID with you for your appointment. Also, please be sure to arrive **45 minutes** early to complete registration.

Our office will give a courtesy call for appointment reminders 48hrs in advance (please do not rely on this call in-case system is down). We do ask that if you need to cancel or reschedule appointment you give 24hr notice. If you No Show for appointment we will attempt to call you 3 times for reschedule. If we are unable to contact via phone, we will send a reminder letter & contact your referring provider.

You may receive bills from TMH Physician Partners, Tallahassee Memorial Hospital, or other organizations for services provided such as office visits, lab tests, x-rays, treatments, etc.

Please be prepared to discuss and pay any possible co-pays, deductibles, or co-insurance at each visit.

If you have any questions regarding any of the above information or your appointment, feel free to give us a call at (850) 431-5360. We look forward to seeing you soon!

Thank you,

TMH Physician Partners Cancer & Hematology Specialists

1775 One Healing Place, Tallahassee, Florida 32308 | Telephone: (850) 431-5360 Fax: (850) 431-5367

TALLAHASSEE MEMORIAL HEALTHCARE
PHYSICIAN PARTNERS
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Full Name: _____ Patient prefers to be called: _____

Date of Birth: _____ Social Security #: _____- _____-_____ Sex: □Male □Female

Mailing Address:_____ Apt/Unit#:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____Cell Phone: (_____)_____

Marital Status: □ Single □ Married □Divorced □Widowed □Separated Email: _____

Referring Physician: _____ Primary Care Physician: _____

Patient's Employer Name: _____

Employment: □ Full-time □Part-time □Not working □ Self Emp □ Retired □ Military Student: □Full-time □Part-time □N/A

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone: (_____)_____ Emergency Contact Other Phone:(_____)_____

FOR CHILDREN - guarantor information/responsible for payment:

Guarantor Name: _____ Guarantor Relationship:_____

Guarantor Date of Birth: _____Guarantor Address: _____ Apt/Unit#: ____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION- <u>PRIMARY PLAN</u> -POLICY INFORMATION

Insurance Company:_____ Subscriber name: _____

Cert/Policy #: _____ Group Name: _____

Group#:_____ Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □Child □ Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: ____ Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

INSURANCE INFORMATION - <u>SECONDARY PLAN</u> - POLICY INFORMATION

Insurance Company:_____ Subscriber name: _____

Cert/Policy #: _____ Group Name: _____

Group#:_____ Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □ Child □ Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: ____ Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

EDUCATION: We want to provide education regarding your health conditions and would like to know the following:

My Preferred teaching method is: □ I have no preference □ Written education materials □ Demonstration

Barriers to learning: □ Language barrier □ Poor eyesight □ Poor Hearing □ Other _____
□ No barriers

Would you like someone with you during any education? (Name)_____(Relationship) _____

Primary Language: □English □Spanish □Other: _____

Race: □ Asian □ African American □American Indian □ Caucasian □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other: _____

Contact Preference: □ Phone □ Email □ Text _____

TMH PHYSICIAN PARTNERS

Tallahassee Memorial HealthCare, Inc.

1. Consent and Acknowledgements Relating to My Care and Treatment:
I hereby consent, for myself or, a minor child or another person for whom I have authority to sign to the rendering of medical care and treatment **(including but not limited to medicinal drugs, diagnostic tests and procedures),** that my attending physician(s) and/or other TMH Medical Staff members consider necessary and advisable to treat while a patient of a provider of Tallahassee Memorial HealthCare (TMH). I acknowledge that my medical care and treatment may be provided by physicians (including residents), physician assistants, nurses, medical and allied health students and other health care providers. In addition, I consent to the appropriate disposal by TMH of any specimens or other bodily materials removed during a technical procedure or for testing purposes.

2. Assignment of Benefits/Consent to Release My Information to TMH: I assign to TMH all my right, title and interest in benefits due from any and all insurance carriers, health care plans, health plan administrators, benefit programs, the Centers for Medicare and Medicaid Services (and their agents and review agencies) and/or other payment sources ("Payers"). I authorize my Payers to make payments directly to TMH of any benefits due for services provided by TMH. I acknowledge that TMH has the right to accept or refuse assignment of medical benefits. If my Payers will not allow direct payment to TMH or if TMH refuses to accept assignment of medical benefits, I agree to pay TMH all payments that I receive for services. I consent to my Payers providing TMH with all pertinent financial information concerning coverage and payments made under my health care plans.

3. Notice of Privacy Practices: I acknowledge that a copy of the TMH Notice of Privacy Practice has been provided to me, and that an electronic version of that document is available at www.tmh.org.
Please Initial_____

4. Patient's Rights and Responsibilities: I acknowledge that the TMH Patient's Rights and Responsibilities, has been provided to me, and that an electronic version of that document is available at www.tmh.org
Please Initial_____

5. Advance Directives. Information about your rights to make advance health care decisions (including but not limited to a Living Will, Healthcare Power of Attorney, and Designation of Healthcare Surrogate), as well as your healthcare providers' policies regarding the same can be found on this document, and electronically at www.tmh.org ☐ **YES or** ☐ **NO**

Do you have an Advance Directive?
Policy and Procedure on Advance Directives in The Outpatient Clinic Setting:
Patients will receive screening for advance directives during registration of their first visit to the TMH outpatient clinics. Patients are not required to have an advance directive.
Making Your Wishes Known
Advance directives outline predetermined actions you have indicated you desire for your healthcare if you are no longer able to make decisions for yourself due to incapacity or illness. These legally binding documents outline your wishes regarding life support, resuscitation and other interventions for both your healthcare team and your family members.
Living Will
A living will is a written, legal document that spells out medical treatment you would and would not want to be used to keep you alive if you have a terminal condition and cannot speak for yourself.
Healthcare Decision Maker
Your healthcare decision maker is another adult you appoint to make decisions on your behalf when you are unable to do so. It is usually recommended that you appoint someone who knows your wishes and is willing to carry them out, especially regarding your personal, religious, moral, and cultural beliefs. This can be done by signing a written designation of a healthcare surrogate that complies with Florida law. If you are incapacitated, your healthcare surrogate will have the authority to make all the medical decisions regarding your healthcare, including decisions about when to withhold or withdraw life-prolonging procedures.
Durable Power of Attorney
A durable power of attorney for healthcare is another legal document that can be used to name your healthcare decision maker. Once written, it should be signed dated, witnessed, notarized, and copied, and put into your medical record.

IN THE EVENT THE PATIENTS NEED EMERGENCY CARE IN THE OUTPATIENT CLINIC SETTING, WE WILL PROVIDE BASIC LIFE SUPPORT AND CALL 911 TO SUMMON EMERGENCY LIFE SERVICES, UNLESS A PHYSICIAN WHO IS FAMILIAR WITH THE PATIENT'S WISHES AND MEDICAL HISTORY ORDERS OTHERWISE.

This policy is in place because it may not be possible in an emergency situation in the outpatient clinic to determine your chance of survival or recovery. Once you have reached the Emergency Room or Hospital where a better determination of your condition can be made, your advance directive will be honored if you are not able to express your wishes. If you have an advance directive, please bring us a copy of your advance directive so we can electronically scan it into your medical record.

If you need additional information, you may contact an attorney or the Risk Management Department at TMH- 850-431-5364.

Patient Name_____

Patient DOB _____

Lawson# 78301 Rev. (06/2022) TMH192

6. Consent for TMH to Release My Medical Information: I hereby authorize TMH to release my medical information to the following persons/entities (my "medical information" includes but is not limited to information relating to the following: medical, psychological, psychiatric, HIV/AIDS, communicable and sexually transmitted diseases, genetic testing and alcohol/drug abuse):

- My other health care providers for treatment or payment purposes, as well as my primary care provider (if I have provided TMH with the name of such provider);
- Payers for the purpose of processing health care claims; additionally, TMH may share my past, current and future health, treatment and patient records about services received from TMH and other providers for the purpose of managing or coordinating my care and improving the quality of that care;
- Person(s) I designate as my guarantor(s) for handling billing and payment of my account;
- Accrediting and quality organizations, regulatory agencies and/or other persons or entities for health care operations; and
- Persons, entities, agencies, and/or other health care providers as required by law, including but not limited to Section 395.1052, Fla. Stat.

7. Health Information Exchange (HIE): An HIE is designed to provide all your medical providers with quick access to medical records to make treatment more effective and efficient. The HIE may limit the need to repeat tests that have already been done, and provide important information that you may not be able to provide because of confusion, stress other medical emergencies. TMH will follow state and federal laws, including HIPAA, when protecting the release of sensitive information. Sensitive information includes but is not limited to behavioral health, drug/alcohol/substance abuse, abuse treatment, sexual abuse, genetics testing, HIV/STD and adoption records. I understand that my information from my medical records will be exchanged among my health care providers through a HIE network. Participating in the HIE is not a condition to receive health care, and I may opt out of participating in the HIE.

If you wish to Opt-Out of the HIE please check ☐ Opt-Out.

8. Acknowledgment Regarding Billing:
I understand that I will receive one or more bills from TMH for the services provided**.** I understand that I will also receive one or more separate bills from the physicians who provide care while I am at TMH, including but not limited to surgeons, Anesthesiologists, Radiologists, Emergency Physicians, Pathologists and other specialists. Pathologists are responsible for analysis of specimens and assuring test results are clinically valid, reliable, and reported in a timely manner to my doctor. I agree to pay for those pathology services unless the pathologist has entered into an agreement with my insurance company to accept payment in full or unless otherwise provided by law.

9. Acknowledgment of Financial Responsibility: I acknowledge that I am responsible and obligated to pay for all charges for services provided, including but not limited to any amount not paid by my Payers, which includes but is not limited to Medicare, a health maintenance organization, an out-of-state workers' compensation policy, or any other Payer. I consent to TMH obtaining consumer credit reports to determine my eligibility for financial assistance and/or payment options. I agree, whether I sign as the patient or as the parent, guardian, spouse, agent or guarantor of the patient, that I am obligated to pay TMH for the services rendered to the patient; if the account is referred to an attorney or collection agency for collection, I agree to pay the reasonable attorneys' fees and costs of collection.

10. Notice to Medicare Patients: I understand that Medicare will not cover certain drugs. I understand that any tablet, capsule, suspension (including eye drops), ointment, patch or suppository will not be paid by Medicare in an outpatient setting even if my doctor ordered it and I received it. If I am unable to pay, please call the Central Business Office at 850-431-7289.

11. **HMO ELIGIBILITY GUARANTEE**: I hereby certify that if I enrolled in an HMO and/or Medicaid HMO that I am receiving health care services through the Primary Care Physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a statement/bill from TMH.

12. Consent to Contact Me: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from TMH and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services and goods provided by TMH or its affiliates that may be of interest to me. I understand if this information is provided to a third party, this information will no longer be protected by the person or entity that received the information in accordance with applicable law. TMH may not condition treatment, payment, enrollment or eligibility for benefits on your agreeing to this provision.

13. Consent to Photograph/Video: I consent to TMH physicians and staff taking photographs and/or video to be used in connection with my diagnosis, care and treatment, and such photos and videos are the property of TMH. I acknowledge that I may withdraw my consent at any time and that my medical care is not dependent on my agreement to have photographs and/or video taken.

Patient Name_____

Patient DOB _____

14. Prohibited Items: I acknowledge that pursuant to TMH policy, I am prohibited from bringing to TMH any weapon, explosive device, illegal substance or drug or any alcoholic beverages. I understand that if there is any violation of this policy, TMH will request that the items be removed. I understand that if I am non-complaint this may result in notification to TMH security and/or law enforcement.

15. Personal Valuables: I understand that TMH does not accept responsibility for any personal property (monetary or sentimental).

By signing below, I acknowledge and agree that I understand, accept and agree to be bound to the terms of this document. I understand that I have the right to revoke the authorizations in this document at any time by notifying TMH in writing, except to the extent that TMH has already taken action in reliance on them. These authorizations remain valid unless/until I revoke them in writing.

I CERTIFY AND STATE THAT I HAVE RECEIVED NO PROMISES, ASSURANCES, OR GUARANTEES FROM ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY MEDICAL TREATMENT OR SERVICES.

- If the patient is 18 years of age or older, the patient must sign and date this form.
- If the patient is 18 years of age or older and incapable of signing, a legally authorized person may sign and date the form; please indicate your legal authority and include documentation of that authority:
  ☐ **Legal Guardian** ☐ **Health Care Surrogate/Power of Attorney** ☐ **Spouse/Proxy**
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law; please indicate your authority:
  ☐ **Parent** ☐ **Legal Guardian**

PRINT PATIENT NAME	**PATIENT DATE OF BIRTH**
PRINT LEGAL REPRESENTATIVE NAME	**DATE**
SIGNATURE PATIENT/LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

Patient Name_____

Patient DOB _____

PATIENT PROFILE

Date: _____ Sex: ☐ Male ☐ Female Date of Birth: _____

Name (Last, First): _____

Have you had a colonoscopy?		YES		NO	If yes, when:___/____/___	Where:
Have you had a mammogram?		YES		NO	If yes, when:___/____/___	Where:
Have you had a bone mineral density test (DEXA scan)?		YES		NO	If yes, when:___/____/___	Where:

IMMUNIZATIONS: Are your immunizations current? ☐ YES ☐ NO

Date of last Tetanus: ____/____/____	Date of Flu vaccine: ____/____/____	Date of Pneumonia vaccine: ____/____/____	Date of Shingles vaccine: ____/____/____

Patient Health Questionnaire-2 (PHQ-2):

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Have you experienced 10 lbs weight loss or gain in past 3 months?		YES		NO				
Do you have problems with mobility (use a wheelchair, cane, or walker)?		YES*		NO				
*If **YES** describe the problem and/or the device used:								
Have you had a fall in the past year?		YES		NO				
Do you feel unsteady?		YES		NO				
Are you in a relationship where you are being threatened or hurt?		YES		NO				
Are there any religious considerations that would keep you from receiving blood products?		YES		NO				
Within the past 12 months we worried whether our food would run out before we got money to buy more		Often True		Sometimes True		Never True		
Within the past 12 months the food that we bought didn't last and we didn't have money to get more		Often True		Sometimes True		Never True		

PAST MEDICAL HISTORY:

Have you ever had any of the following? (Please Check)

☐ High Blood Pressure	☐ Diabetes	☐ Hepatitis	☐ Pacemaker/Defibrillator
☐ Heart Rhythm Disease	☐ Glaucoma	☐ Lupus	☐ Heart Failure
☐ Rheumatic Fever	☐ Osteoarthritis	☐ Cirrhosis	☐ Heart Rhythm Disease
☐ Emphysema or COPD	☐ Rheumatoid Arthritis	☐ Colitis	☐ Heart Attack
☐ Asthma	☐ Stomach Ulcers	☐ Gallstones	☐ Coronary Artery Disease
☐ Acid Reflux Disease	☐ Clotting Problems	☐ Glaucoma	☐ Sjogren's Syndrome
☐ Pancreatitis	☐ Diverticulitis	☐ Tuberculosis	☐ Rheumatic Fever
☐ Low Thyroid	☐ Scleroderma	☐ Seizures	☐ Stroke
☐ Asbestos Exposure	☐ Bone Fracture after 50	☐ Blood Clots	☐ Steroid use >6months
☐ Thyroid	☐ OTHER:		

Have you been diagnosed with cancer before?

Type of Cancer:	Where treated (Doctor, Hospital, City)	When (Dates)

Have you had Chemotherapy? ☐ YES ☐ NO Why?_____ When?_____
Which drugs?_____
Where did you receive it?_____

Have you had Radiation Therapy? ☐ YES ☐ NO Why?_____ When?_____
Number of Treatments?_____ Where did you receive it?_____

List all past surgeries:_____
_____

FAMILY HISTORY OF CANCER: **Adopted?** ☐ Yes ☐ No

Relative	Type of cancer	Age when diagnosed	Alive?

SOCIAL HISTORY:

Education: Check last year completed:
Grade School: ☐ 1-5 ☐ 6-8 High School ☐ 9 ☐ 10 ☐ 11 ☐ 12 College: ☐ Bachelor ☐ Masters ☐ Doctorate

OCCUPATION: CHECK ONE OR MORE:

☐ Employed/Self Employed If employed, describe the work you do:_____
☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

If retired, your occupation prior to retirement:_____

If disabled, describe disability and date work stopped:_____

ALCOHOL & TOBACCO USE:							
Do you smoke cigarettes?		YES		NO	# packs per day:		How many years?
Have you ever smoked for period					# packs per day:		How many years?
of five (5) or more years?		YES		NO			
Are you interested in stopping?		YES		NO			
Are you an ex-smoker?		YES		NO	If "yes" when did you quit?_____		
Regular alcohol/beer intake:		YES		NO	Per Day?____ Per Month?____		
Are you an ex-drinker?		YES		NO	If "yes" when did you quit?_____		

SOCIAL ISSUES: If "Yes", Please Explain					Explanation
Do you live alone?		YES		NO	
If not, who lives with you?					
Do you have transportation issues?		YES		NO	_____
Do you need assistance with your Activities of daily living?		YES		NO	_____
Do you have financial concerns?		YES		NO	_____
Concerned about your coping abilities, or your family's ability to cope?		YES		NO	_____
Do you have any Marital concerns?		YES		NO	_____
Have you ever been the subject of violence in your home?		YES		NO	_____

ALLERGIES: NO KNOWN ALLERGIES: ☐

MEDICATION	REACTION
1.	
2.	
3.	

MEDICATIONS:

****Preferred Pharmacy _____ ****Location_____**

List any medications you are taking, including vitamins and all non-prescription drugs. Copy names and dosages of medication from the prescription label. Attach an additional sheet of paper if needed.

Name of Medication	How Often	Dosage (mgs/tablets)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

REVIEW OF SYSTEMS: In the past 3 months, have you experienced any of the following:

CONSTITUTIONAL

Lack of appetite	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Lethargy/fatigue	☐ Yes	☐ No
Night sweats/chills	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No

How much? _____

HEAD/EYES/EARS

Hair Loss	☐ Yes	☐ No
Pain in Eye	☐ Yes	☐ No
Eye injury	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Blurry/Decreased Vision	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No
Earaches	☐ Yes	☐ No
Buzzing or ringing in ears	☐ Yes	☐ No
Sensation of spinning	☐ Yes	☐ No

NOSE, THROAT, NECK

Recurrent sore throats	☐ Yes	☐ No
Persistent Hoarseness	☐ Yes	☐ No
Frequent Nosebleeds	☐ Yes	☐ No
Mouth Ulcers	☐ Yes	☐ No
Oral bleeding	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Swollen lymph nodes or glands	☐ Yes	☐ No

Where_____

Difficulty swallowing	☐ Yes	☐ No
Masses or lumps	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Altered taste	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No

SKIN

Chronic skin condition	☐ Yes	☐ No
Lump or growth on skin	☐ Yes	☐ No
Change in color of skin	☐ Yes	☐ No
Skin Tumors or moles	☐ Yes	☐ No
Rash	☐ Yes	☐ No

BREASTS

Masses or lumps	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No
Nipple inversion	☐ Yes	☐ No
Pain	☐ Yes	☐ No

HEART

Chest pain	☐ Yes	☐ No
Ankle swelling	☐ Yes	☐ No
Sleeping with head elevated	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Calf cramps with walking	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

LUNG

Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Blood in sputum	☐ Yes	☐ No
Wheezing/asthma	☐ Yes	☐ No
Tuberculosis/or exposure	☐ Yes	☐ No
Infections/pneumonia	☐ Yes	☐ No

NEURO

Frequent or severe headaches	☐ Yes	☐ No
Dizziness or faintness	☐ Yes	☐ No
Nervousness/Anxiety	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Disorientation	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Abnormal gait	☐ Yes	☐ No

GASTROINTESTINAL

Frequent heartburn/ indigestion	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea or frequent stools	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Blood in vomit	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Yellow skin/jaundice	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Decreased appetite	☐ Yes	☐ No
Change in stools	☐ Yes	☐ No
Black, tarry stools	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No

BONES AND MUSCLES

Painful joints	☐ Yes	☐ No
Sore muscles	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Decreased range of motion	☐ Yes	☐ No

ENDOCRINE

Hot flashes ☐ Yes ☐ No
Other endocrine diseases ☐ Yes ☐ No

HEMATOLOGIC/ LYMPH

Bruising ☐ Yes ☐ No
Enlarged lymph nodes ☐ Yes ☐ No

GENITOURINARY

Decreased size/force of urine stream ☐ Yes ☐ No
Increased frequency of urination ☐ Yes ☐ No
How often? _____
Burning sensation during urination ☐ Yes ☐ No
Nighttime urination ☐ Yes ☐ No
How many times @ night _____
Sensation that bladder cannot empty ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Erectile dysfunction (men only) ☐ Yes ☐ No
Incontinence ☐ Yes ☐ No

PSYCHIATRIC

Delusions/Hallucinations ☐ Yes ☐ No
Mood swings ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No
Body Dysmorphic Disorder ☐ Yes ☐ No
Post-Traumatic Stress Syndrome ☐ Yes ☐ No
Paranoia ☐ Yes ☐ No
Bi-Polar ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No
OTHER ☐ Yes ☐ No

WOMEN ONLY

Age at first menstruation: _____ Date of last period: _____ Last Pap _____
Number of Pregnancies _____ Number of live births _____
Age of children _____
Vaginal Discharge or bleeding ☐ Yes ☐ No
Irregular periods ☐ Yes ☐ No
Painful Intercourse ☐ Yes ☐ No
Ever use hormones? ☐ Yes ☐ No
Gone through menopause? ☐ Yes ☐ No If "yes", when? _____
Date & location of mammogram showing cancer:_____
Date & location of last normal mammogram: _____

PATIENT PHYSICIANS INFORMATION

Who referred you to our office? _____
Primary Care Physician: _____
General Surgeon: _____
Oncology Physician (Chemo Doctor) _____
Radiation Oncology Physician (Radiation Doctor) _____
Pulmonary Physician (Lung Doctor) _____
Neurology/Neurosurgery Physician (Brain Doctor) _____
Dermatology Physician (Skin Doctor) _____
Urology Physician (Bladder/Prostate Doctor) _____
Cardiology Physician (Heart Doctor) _____
Gastroenterology Physician (Stomach Doctor) _____

List all upcoming Physician Appointments:

_____
_____

TMH PHYSICIAN PARTNERS

Verbal Communication Authorization

To protect a patient's privacy and to ensure that our physicians and medical clinic staff members know whom they have permission verbally to communicate with regarding your protected health information contained in your medical and billing records please complete below. Release of information under this document is limited to verbal discussions with my Health Care Provides. This document does not permit release of any written health information to the individuals named below.

Patient Name:_____ **Date of Birth:** _____

I authorize TMH, their physicians, nurses, and other health care personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care and payment of my care.

The information indicated above may be released to (family members/friends):

Name	**Relationship**	**Phone number**
1.		
2.		
3.		

_____ ***(Initial)*** I specifically authorize the verbal release of all medical information, **INCLUDING** that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

_____ ***(Initial)*** I specifically authorize the verbal release of all medical information, **EXCLUDING** that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

Special Instructions or Restrictions on Disclosure: Other: _____

May we leave a voicemail at the number(s): ☐ Yes ☐ No

May we leave a text message at the number(s): ☐ Yes ☐ No

(I understand that texting is not a secure form of communication)

This authorization is limited to the following timeframe from _____ to _____. If no date indicated, this form will remain in effect for an unlimited amount of time.

I understand that I have the right to revoke this authorization at any time, if I do so, it must be in writing and addressed to TMH. The revocation will not apply to any information already released as a result of this authorization. I also understand once the information is released, there is potential for re-disclosure by the recipient and no longer protected by applicable state and federal regulations. I understand this authorization is voluntary. I do not need to sign this form in order to receive treatment.

_____

Patient/Legal Representative Signature Date

_____

If authorization is by Legal Representative (Print Name) Relationship to Patient

_____

Witness

Tallahassee Memorial Cancer Center

Tallahassee Memorial Cancer Center
1775 One Healing Place, Tallahassee, Florida
Located near the corner of Miccosukee and Surgeons Drive

Phone 850-431-ICAN (4226)

We are pleased to announce that the following services are now being performed at our new Cancer Center facility:

TMH PHYSICIAN PARTNERS

- Radiation Oncology
- Cancer & Hematology
- Gynecologic Oncology
- Surgical Oncology

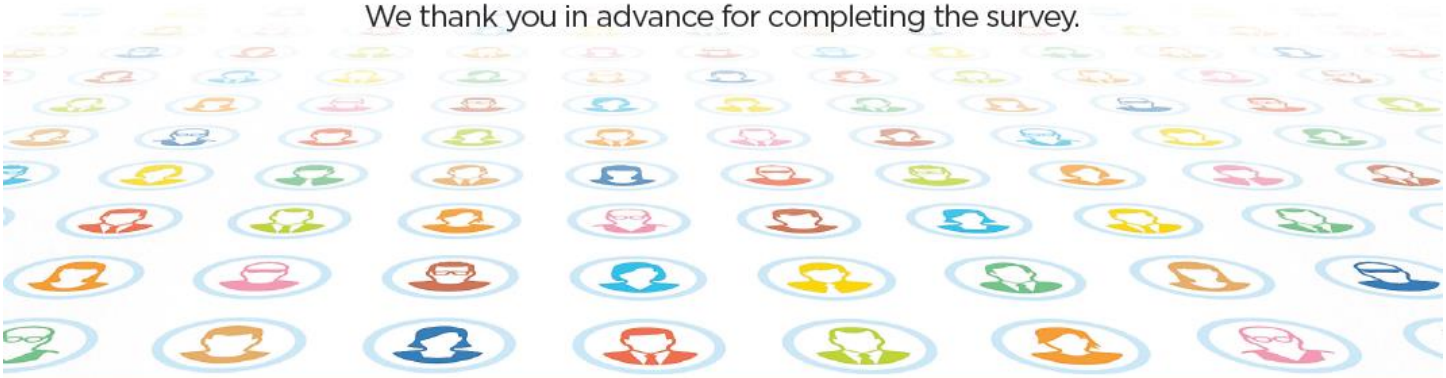
TALLAHASSEE MEMORIAL HEALTHCARE – OUTPATIENT SERVICES

OP Infusion
Navigation and Counseling Services
Survivorship Programming
Nutrition Assessments
Music Therapy
Animal Therapy
Cancer Research and Registry

YOUR EXPERIENCE IS IMPORTANT TO US

We want to be the best, and you can help.

After your visit at TMH, you may receive a survey asking about your experience.
Help us recognize outstanding caregivers, and/or provide feedback where we can improve.
We thank you in advance for completing the survey.



TALLAHASSEE MEMORIAL HEALTHCARE

PRESS GANEY®

You may receive a survey by phone, mail, email or text. Surveys are administered by Press Ganey Associates, Inc. All responses are confidential. Should you need an advocate or have a concern we can address while you are here, please contact Patient Experience Department at 431-5488.

#75473

TALLAHASSEE MEMORIAL HEALTHCARE

Tallahassee Memorial Cancer Center
Authorization For Release of Information

PATIENT INFORMATION
Date(s) of Service Requested:

___/___/___ to

___/___/___

NAME: _____ DATE OF BIRTH: ___/___/___

LAST 4 NUMBERS OF SSN: _____ DAY PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RELEASING PARTY (***Who*** has the information you want released?)

- □ Tallahassee Memorial Hospital
- □ Tallahassee Memorial Behavioral Health Center
- □ Tallahassee Memorial Rehabilitation Center
- □ Tallahassee Memorial Cancer Center
- □ Tallahassee Memorial Clinic/ Physician Partners (*specify location*)_____
- □ Tallahassee Memorial Wound Care
- □ Tallahassee Memorial Urgent Care
- □ Tallahassee Memorial Home Health Care
- □ Other

RECEIVING PARTY (***Where*** do you want the information sent? ***Who*** may have the information?)

NAME:_____

ADDRESS:_____ DAY PHONE:_____

CITY:_____ STATE:_____ ZIP CODE:_____

FAX NUMBER: _____ **(URGENT PATIENT CARE ONLY)**

HOSPITAL (check all that apply):

- □ Hospital Summary
- □ Discharge Summary
- □ History and Physical
- □ Consultation Reports
- □ Operative Reports
- □ Laboratory Reports
- □ Radiology Reports/ X-Ray Reports
- □ Pathology Reports
- □ Entire Record (not including psychotherapy notes)
- □ Emergency Record
- □ Cardiac Reports/ EKG
- □ Other_____

OFFICE/CLINIC (check all that apply):

- □ Office Visits
- □ Immunizations
- □ Physical Exam
- □ Laboratory Reports
- □ Radiology Reports
- □ Clinic Summary
- □ Other_____
- □ Entire Record (not including psychotherapy notes)

BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply):

- □ Hospital Summary
- □ Discharge Summary
- □ Assessments
- □ Progress Notes
- □ Laboratory Reports
- □ Medications
- □ Entire Record (not including psychotherapy notes)

FORMAT: □ USB/ CD □ Paper □ Other_____

DELIVERY METHOD: □ Mail □ Pick-up □ Fax, where permitted

PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at anytime. I must cancel in writing to the Privacy Officer at the above address; **2)** Any cancellation will apply only to information not yet released by facility or practice; **3)** Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; **4)** Refusing to sign this form will not prevent my ability to get treatment; **5)** TMH will not share or use my health information without my permission other than by ways listed in TMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; **6)** A fee may be charged for providing the protected health information; **7)** I have a right to receive a copy of this form upon my request.

I DO NOT WANT TO RELEASE (check all that apply):

□ **HIV/AIDS** □ **GENETIC INFORMATION** □ **SEXUALLY TRANSMITTED DISEASE (STD)** □ **DRUG/ALCOHOL** □ **MENTAL HEALTH**

This permission expires one year after the date of my signature unless another date or event is written here:_____

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

Witness Signature: _____ **Print Name:**_____ **Date:**_____

Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral/ mental health without parental consent, the minor must sign this authorization.

Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form.
Check the box below to indicate the relationship/ authority (Written Proof May be Requested):

□ Healthcare Agent/ POA □ Guardian □ Executor/Administrator/Attorney in Fact □ Spouse
□ Parent □ Adult Child □ Affidavit Next of Kin □ Other_____

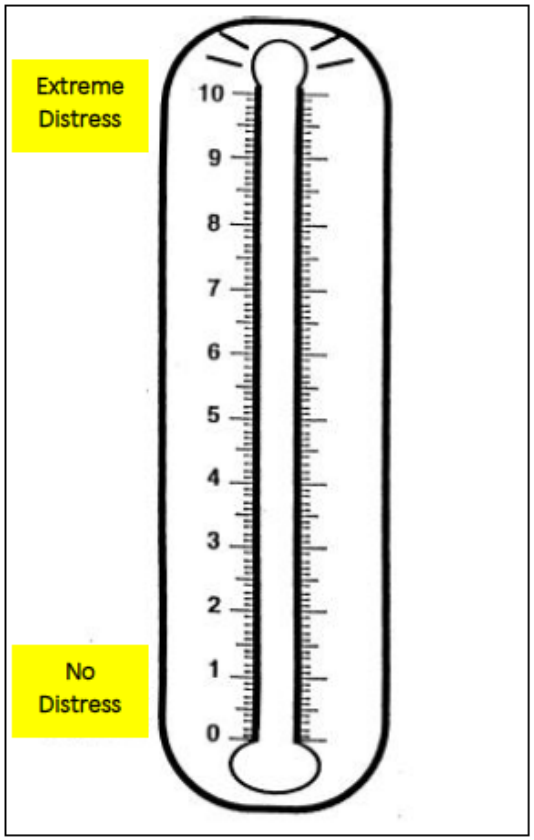
TALLAHASSEE MEMORIAL HEALTHCARE

SCREENING TOOLS FOR MEASURING DISTRESS

Date: _____

Patient Name: _____ **Patient's Date of Birth:** _____

First, please circle the number (0-10) that best describes how much distress you have been experiencing in the past week, including today.



Adapted from the NCCN 2.2016 *Distress Management* Clinical Practice Guidelines in Oncology. National Comprehensive Cancer Network, 2016. Available at: http://www.nccn.org. Accessed 2016.
To view the most recent and complete version of the guideline, go online to www.nccn.org.

Secondly, please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check YES or no FOR each.

YES	NO	PRACTICAL PROBLEMS
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/school

YES	NO	FAMILY PROBLEMS
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children

YES	NO	EMOTIONAL PROBLEMS
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities

YES	NO	
☐	☐	Spiritual/Religious concerns

YES	NO	PHYSICAL PROBLEMS
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/Itchy
☐	☐	Sleep
☐	☐	Substance Abuse
☐	☐	Tingling in hands/feet

Other Problems/Comments: _____

_____

_____

NOTICE OF PRIVACY PRACTICES OF:

Tallahassee Memorial Hospital and Tallahassee Memorial HealthCare, Inc.

Effective Date: April 14, 2003 Revised Date: June 1, 2017

This notice describes the privacy practices of all inpatient and outpatient departments and units of Tallahassee Memorial Hospital and all facilities operated by Tallahassee Memorial HealthCare, Inc. with the exception of Tallahassee Memorial Behavioral Health Center.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. PURPOSE OF THE NOTICE OF PRIVACY PRACTICES

A record is made of the care and services you receive each time you are a patient in our hospital or one of our affiliated facilities. This record documents such things as your physical examination, test results, diagnosis, treatment, plans for future care, and information related to billing. We need this record to provide you with quality care and to comply with certain legal requirements. This notice describes the type of information we gather about you while you are a patient, with whom that information may be shared and the safeguards we have in place to protect it. It applies to all records of your care generated by hospital personnel, agents of the hospital, or your doctor. Please note that your doctor may provide you with a notice regarding the use and disclosure of your health information in his particular office.

B. OUR LEGAL DUTY REGARDING YOUR MEDICAL INFORMATION

We are required by law to keep private any medical information that identifies you and provide you with a description of our privacy practices with respect to your medical information. We will follow applicable laws and the terms of the notice that are currently in effect.

C. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. Permitted and Required Uses and Disclosures of Your Health Information Which DO NOT Require Your Written Authorization or the Opportunity for You to Object or Agree

The following categories describe the different ways that we may use and disclose medical information and examples of each. Not every possible use or disclosure in a category will be listed.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different healthcare professionals also may share health information about you in order to coordinate the different things you may need, such as medications, lab work, meals, and x-rays. We may also disclose medical information about you to people outside the facility who may be involved in your medical care after you are discharged or that provide services that are part of your continuing care.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us or reimburse you. We may also use and disclose medical information about you to obtain prior approval or determine whether your insurance plan will cover the treatment. We may contact you for the purpose of billing/collection efforts. This may include leaving a message on your answering machine/voice mail.

For Health Care Operations: Members of our medical staff, clinical departments, and administrative units may use information in your medical record to review the care and outcomes in your case and similar cases. This is necessary to continually improve the quality of care for all patients we serve. For example, we may disclose information to doctors, nurses, technicians, training doctors, medical students, and other facility personnel for review and learning purposes. We may also use and disclose health information to assess your satisfaction with our services and for reviewing the competence of health care professionals.

Business Associates: Certain services are provided in our organization through contracts with business associates. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Some examples include CPA firms whose accounting services involve access to protected health information, healthcare clearinghouses that transmit claims on our behalf, independent medical transcriptionists who type medical reports, or a copy service we use to make copies of your health record. To protect your privacy, we require each business associate to sign an agreement that obligates the business associate to use appropriate safeguards to protect your health information.

Funeral Directors and Medical Examiners: Consistent with applicable law, we may use and disclose your health information to funeral directors and medical examiners in the event of your death.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law. This may include, but is not limited to requests from the following types of entities: 1) Food and Drug Administration; 2) Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability; 3) Governmental Authority which by law receives the reports of child abuse and neglect; 4) Protective Services for Victims of Abuse, Neglect or Domestic Violence; 5) Correctional Institutions; 6) Workers Compensation Agents; 7) Organ and Tissue Donation Organizations; 8) Military Command Authorities; 9) Health Oversight Agencies; 10) National Security and Intelligence Agencies; 11) Protective Services for the President and Others.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. This may include leaving a message on your answering machine/ voice mail.

Fundraising Activities: We may use health information about you in an effort to raise money for Tallahassee Memorial HealthCare, Inc. and its operations. We may disclose certain information to the TMH Foundation so that the Foundation may raise money for the hospital. You have the right to request (opt-out) that we not contact you for fund raising efforts. **If you do not want to be contacted for fundraising efforts, you must notify us as directed by the fundraising communication (correspondence) or notify our Privacy Oficer by phone or in writing at the number or address on the last page.**

Affiliated Covered Entities: Protected health information will be made available to personnel at all facilities affiliated with and managed by Tallahassee Memorial HealthCare as necessary to carry out treatment, payment, and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the TMH Privacy Oficer for further information on the speciic sites which are afiliated with TMH.

Organized Health Care Arrangement: Our facilities and their medical staff members share an organized health care arrangement. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Data Aggregation: We may disclose protected health information to permit data aggregation with other health care providers for our health care operations such as quality assessment and improvement activities, population health analysis or clinical guideline development.

De-identified Information: We may use or disclose protected health information to create de-identified information which is not individually identifiable health information.

2. Uses and Disclosures of Your Health Information Which DO Require That You Have the Opportunity to Object or Agree

We may disclose the following kinds of health information about you, if you are informed in advance of the use and disclosure, and you have had the opportunity to agree to or prohibit or restrict the use and disclosure of this information. We may inform you verbally or in writing of these types of uses and disclosures, and you may agree or object verbally or in writing to these

uses and disclosures.

Directory: We may include certain limited information about you in our facility directory while you are a patient here. This information may include your name and location, (whether an inpatient, outpatient, or Emergency Center patient.) It may also include your general condition (e.g. fair, stable, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you do not want to be included in the directory, please advise the Registration staff and request the "Opt Out Form".

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who is responsible for or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Health Information Exchange: We may disclose protected health information to a health information exchange or other similar organization for treatment purposes and health care operations, such as quality assessment and improvement activities, population health analysis or clinical guideline development, and other purposes consistent with federal and state law. **If you do not wish your protected health information to be shared with a health information exchange, please advise the Registration staff and request the "HIE Opt Out Form."**

3. Uses and Disclosures of Your Health Information Which Require Your Authorization

The following uses and disclosures will be made only with your written permission: 1) Most uses and disclosures of psychotherapy notes; 2) Disclosures that constitute the sale of your protected health information; 3) Uses and disclosures for marketing purposes.

D. YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your medical record is the physical property of the healthcare practitioner or facility that compiled it; however you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and obtain a copy your medical information, you must submit your request in writing to our Privacy Officer or our Director, Medical Records at the address at the end of this notice.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional selected by Tallahassee Memorial HealthCare will review your request and the denial. We will comply with the outcome of the review.

Amend: If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required. To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. With the exception of "Out-of-Pocket Payments," described below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. Restrictions may be terminated upon your oral or written agreement, your written request or upon you receiving a notice from us that we are terminating the agreement to a restriction.

To request restrictions regarding your presence and/or location in the facility, you must make this known when you register or check-in as a patient.

Out-of-Pocket Payments: If you prefer that we not bill your health plan for a specific item or service and you have timely paid out-of-pocket in full for that specific item or service, then you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Your request to limit disclosure in this way must be submitted in writing.

Request Conidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing to our Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

Notifcation off a Breach: You have the right to be notified of any breach of your unsecured protected health information.

A Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.tmh.org. To obtain a paper copy of this notice, please request one when you register or check-in as a patient or contact our Privacy Officer.

E. OTHER USES OF MEDICAL INFORMATION WHICH REQUIRE YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing to our Privacy Officer, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

F. CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and include the effective date. You have the right to obtain a copy of the revised notice upon request.

G. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the TMH Privacy Officer at the address below or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized ffor iling a complaint.

H. TALLAHASSEE MEMORIAL HEALTHCARE PRIVACY OFFICER

You may contact the TMH Privacy Officer at 850-431-5339. Written requests or inquiries may be sent to:

Privacy Officer (OR) Director, Medical Records (for record copy request)
Tallahassee Memorial HealthCare, Inc.
1300 Miccosukee Road
Tallahassee, FL 32308

Secretary of the Department of Health and Human Services
Region IV-Office of Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, SW Atlanta, GA 30303-8980
Phone: 404-562-7886 Fax: 404-562-7881
OCRComplaint@hhs.gov

TALLAHASSEE MEMORIAL HEALTHCARE