FLORIDA CANCER SPECIALISTS & Research Institute

Dear Patient,

Welcome to Florida Cancer Specialists & Research Institute (FCS)! Throughout your time with us, you will meet a dedicated team of nurses and other professionals. Each is committed to addressing your concerns and providing the highest quality of care to support you on your journey.

Over the course of your care, you may be assigned to an advanced practice provider (APP) for routine hematology, oncology and symptom management appointments.

APPs are an integral part of our FCS care team. They include advanced practice registered nurses (APRNs) or physician assistants (PAs) who have earned advanced degrees and have specialized training in oncology. They are fully qualified to manage a wide variety of care needs, such as reviewing blood results and pathology and radiology scans. They can also prescribe medications and order infusions.

Individually and collectively, the members of your care team, including our APPs, are centered on you and committed to making sure you achieve the best possible outcome.

In addition to providing excellent care, our APPs play a key role in leading healthcare efforts and improving clinical outcomes. They work closely with your physician, who oversees all aspects of your care plan, to ensure it's personalized to your unique needs.

Feel free to ask questions and let us know how we can help you. Thank you for entrusting your care to us.

Your Florida Cancer Specialists & Research Institute Team

FLORIDA CANCER SPECIALISTS & Research Institute

Name:	**Date of Birth:** ____ / ____ / _____ **SSN:**
Address: **Secondary Address:** From: _____ To: _____	**Gender assigned at birth:** ☐ Male ☐ Female Gender Identity (Select one or fill in): ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
Preferred Language:	**E-mail:** May we email you? ☐ Yes ☐ No
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Race (Select all that apply):** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other:	**Phone Number** Home: Mobile: Preferred Contact: ☐ Home ☐ Cell May we leave a voicemail? ☐ Yes ☐ No **If yes:** ☐ Home ☐ Cell May we text you? ☐ Yes ☐ No **Emergency Contact:** Phone Number: Relationship:
PRIMARY CARE PHYSICIAN: Phone Number: Do you see your PCP at least yearly? ☐Yes ☐No	**PHARMACY:** Pharmacy Phone Number: Pharmacy Address:
REFERRING PHYSICIAN (If different than PCP) Name: Phone Number:	Would you like access to the online patient portal, CareSpace? ☐ Yes ☐ No **<u>If yes,</u>** provide email address above.

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ALLERGIES

Please list all allergies and reactions.

- ☐ CT Dye
- ☐ Iodine
- ☐ Latex
- ☐ Other

MEDICATIONS

Please list all medications you are currently taking, include dosage and frequency.

If you have a printed list, you may provide a copy to the office instead.

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PAST MEDICAL HISTORY

Have you ever been told by a doctor/health care professional that you had cancer? ☐ Yes ☐ No

Type of cancer diagnosed and date:

Treating physician and type of treatment:

Blood Transfusions

Do you have religious restrictions that prevent you from accepting blood transfusions? ☐ Yes ☐ No

Medical History

- ☐ None
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood disorder
- ☐ Cancer
- ☐ Chronic back pain
- ☐ Chronic lung (COPD)
- ☐ Cirrhosis of liver
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug use
- ☐ Enlarged prostate
- ☐ Fracture
- ☐ Freq. urinary tract infections
- ☐ Frequent infections
- ☐ Gallstones
- ☐ GERD/heartburn
- ☐ Glaucoma/cataracts
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart attack-MI
- ☐ Heart disease
- ☐ Heartburn/reflux
- ☐ Hepatitis A/B/C/HIV
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Irritable bowel syndrome
- ☐ Kidney disease/failure
- ☐ Kidney stone
- ☐ Leukemia
- ☐ Lupus-autoimmune
- ☐ Lymphoma
- ☐ Major depression
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Paralysis
- ☐ Parkinson's disease
- ☐ Peripheral vascular disease
- ☐ Pneumonia/bronchitis
- ☐ Problems with anesthesia
- ☐ Raynaud's syndrome
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Shingles
- ☐ Sleep apnea
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid disease
- ☐ Ulcerative colitis

Other:

PAST SURGICAL HISTORY AND HOSPITAL STAYS

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WOMEN'S HEALTH HISTORY (skip if not applicable)

Age menstruation began: Last menstrual period:
Age during first pregnancy (if applicable): Age of menopause (if applicable):
Were you ever on hormone replacement? ☐ Yes ☐ No

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, what? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Other_____ # per day: _____
Have you ever smoked? ☐ Yes ☐ No Started at age: _____Quit at age: _____ Interested in quitting? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, what? ☐ Wine ☐ Liquor ☐ Cocktails ☐ Beer ☐ Other _____
How often? ☐ Daily ☐ Weekend ☐ Socially Drinks per day ☐ 1-2 ☐ 3-5 ☐ >5
Started at age: _____ Quit at age: _____

Children: ☐ Yes ☐ No If yes, how many? _____

Relationship Status:
☐ Single
☐ Married
☐ Partnered
☐ Divorced
☐ Widowed
☐ Other: _____

Occupation Status:
☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Student
☐ Retired
☐ Homemaker
☐ Unable to work
☐ Other: _____

Occupational exposure to hazardous material? ☐ Yes ☐ No **If yes,** ☐ Radiation ☐ Chemicals ☐ Other Particles

HEALTH MAINTENANCE HISTORY

Last GYN exam: Last mammogram: Last colonoscopy or CRC screening test:
Last dental exam: Last CT chest lung cancer screen (if smoker):
☐ EGD date: ☐ EKG/Echo date:
Do you receive prophylactic vaccines? ☐ Yes ☐ No Are you up to date with recommended vaccines? ☐ Yes ☐ No

FAMILY HISTORY

Any bleeding or clotting disorders in family member? ☐ Yes ☐ No
If yes, which relative(s) and what type? _____
Have any family members had genetic testing? ☐ Yes ☐ No
If yes, which relative(s) and what were the results? _____

Relative	Disease	Cancer Type	Age at Diagnosis	Cause of Death
Father				
Mother				
Siblings				
Child(ren)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Other Relatives				

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CURRENT SYMPTONS

General
- ☐ Change in appetite
- ☐ Change in weight
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Frequent colds

Eyes
- ☐ Glasses/contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision

Ears, nose, mouth, throat
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Postnasal drip
- ☐ Dental problems
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums

Heart
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet or ankles

Lungs
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ Difficulty breathing when flat

Musculoskeletal
- ☐ Joint pain/arthritis
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle aches

Genitourinary
- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Urine leakage
- ☐ Pain/burning with urination
- ☐ Pelvic pain
- ☐ Blood in the urine

Men only
- ☐ Prostate infections
- ☐ Impotence

Women only
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful intercourse
- ☐ Cramping

Digestive
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Belching or excess gas
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids

Endocrine
- ☐ Hot flashes
- ☐ Heat intolerance
- ☐ Cold intolerance

Immunologic
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever

Skin
- ☐ Rash, hives or itching
- ☐ Change in color
- ☐ Change in mole or wart
- ☐ A sore that won't heal

Nervous system
- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Convulsions, seizures or tremors
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs

Blood disorders
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood transfusion(s)

Psychiatric
- ☐ Anxiety disorder
- ☐ Major depression
- ☐ Trouble sleeping/insomnia
- ☐ Work/family stress

FLORIDA CANCER SPECIALISTS & Research Institute

GENERAL CONSENT FORM

SMS Communication Consent

☐ I consent to receive text messages from Florida Cancer Specialists & Research Institute (FCS), Rx To Go, LLC, and any authorized texting service vendor for appointment reminders, billing notices, and other health-related updates. I understand message/data rates may apply and I may opt out at any time by replying "STOP."

☐ I do not consent to receive text messages.

Photo Authorization for Medical Record

☐ I consent to FCS photographing me (digital/photo/video) for inclusion in my electronic medical record (EMR) for identification and documentation purposes.

☐ I do not consent to be photographed for medical record purposes.

Consent Disclosure of Medical Information

☐ I authorize FCS to discuss my medical information with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and to no other family members or friends.

Medical Scribe Consent

☐ I give permission for FCS to use a professional medical scribe, who may be virtual, to assist my physician during documentation. I understand this service is provided at no cost and all shared information will remain confidential.

☐ I do not give permission for FCS to use a professional medical scribe.

Florida Cancer Specialists & Research Institute (FCS) is using an AI Scribe tool to improve patient care by helping providers focus more on you during visits. The AI Scribe listens to your conversation with your provider and creates a clinical note, which your provider reviews and approves before it's added to your medical record. Your privacy is protected through strict adherence to federal and state privacy laws and regulations, with added security measures like encryption and multifactor authentication. Participation is voluntary, and you may withdraw consent at any time.

Patient Medication Reconciliation

I consent to FCS and its healthcare providers to collect, document, and reconcile my current medications as part of my medical care. This includes but is not limited to, prescription drugs, over-the-counter medications, vitamins, supplements, and herbal remedies and recording the name, dosage, frequency, and route of administration for each medication. This process is essential for ensuring safe and effective treatment and is required under the Merit-based Incentive Payment System (MIPS) guidelines. I may revoke this consent in writing at any time, except to the extent that action has already been taken based on this consent.

☐ Yes

☐ No

Patient (Print Name) _____ Date of birth _____

Patient (Signature) _____ Date_____

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Advance Care Planning Documents (If yes, please provide a copy)

Do you have an advance directive?	☐ Yes ☐ No	
Do you have a living will?	☐ Yes ☐ No	
Do you have a DNR?	☐ Yes ☐ No	
Do you have a healthcare proxy?	☐ Yes ☐ No	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Florida Cancer Specialists & Research Institute (FCS) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any FCS facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 2890 Center Pointe Drive, Fort Myers, FL 33916.

You may also obtain a copy of the Notice of Privacy Practices by visiting the FCS website at FLCancer.com, select the **Patient Guide** tab, select **New Patient Forms** and click on **Notice of Privacy Policies**.

☐ Accepted ☐ Declined

Patient Name (Print) _____ Date of Birth _____

Patient or Guarantor (Signature) _____ Date _____

Relationship to Patient: _____

REQUEST FOR RELEASE OF RECORDS

I authorize Florida Cancer Specialists & Research Institute (FCS) to request a copy of my complete medical record from the provider listed below:

Name of Provider/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

I understand that by signing this authorization, I permit FCS to receive my medical, psychiatric, HIV, drug/alcohol, and other sensitive health records, unless otherwise restricted by law. I also understand this authorization is valid until revoked in writing.

Patient Name (Print): _____ Date of Birth: _____

Patient or Guarantor Signature: _____ Relationship: _____ Date: _____

FLORIDA CANCER SPECIALISTS & Research Institute

INSURANCE INFORMATION

Patient Name: _____ **DOB:** _____

Primary Insurance Carrier: _____

Name of primary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____ Policy holder's SSN: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____ RX policy number/RX BIN number: _____

I certify that the information provided is accurate. I will notify Florida Cancer Specialists & Research Institute (FCS) of any changes as soon as they become available. I understand that it is my responsibility to update FCS of any changes to my insurance plan, or I may be held liable for the full balance of my treatment.

Patient Name (Print) _____ Date of Birth_____

Patient or Guarantor (Signature) _____ Date_____

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists & Research Institute or Rx To Go for any services furnished by _____. I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient Name (Print) _____ Date of birth_____

Patient or Guarantor (Signature) _____ Date _____

FLORIDA CANCER SPECIALISTS & Research Institute

GENERAL & FINANCIAL CONSENT

Dear Valued Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS' patient general and financial policies:

- You consent to the rendering of medical care in compliance with healthcare surrogacy laws, which may include diagnostic procedures, next-generation sequencing testing and such medical treatment as your physician(s) or other FCS medical staff consider to be necessary. You may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. You consent to initiating and/or receiving technology-based communications with FCS and my providers, including consulting services from a specialist performed virtually. You understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. You have read and understand this General Consent for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.
- You agree to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
    - You understand that FCS patient financial policies are available online at FLCancer.com. You agree that these policies apply to you and may change from time to time without notice.
    - You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and you are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.

FLORIDA CANCER SPECIALISTS & Research Institute

- FCS owns and operates Rx To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use Rx To Go and may have your prescriptions filled wherever you choose. However, if you select Rx To Go to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by Rx To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS' own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS' care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

☐ I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.

A copy is available to the patient upon request.

Patient Name (Print)	Date of birth
Patient or Guarantor (Signature)	Date

For office use:

Name (Print)

FCS Employee (Signature)

FLORIDA CANCER SPECIALISTS & Research Institute

EXPRESS CONSENT TO NEXT GENERATION SEQUENCING

Patient Name: _____ MRN: _____

Patient Date of Birth: _____ Ordering Physician: _____

General description and purpose of genetic test

I understand that my health care provider may recommend that I receive a next-generation sequencing test (NGS). By signing this form, I consent to the collection, use, retention, maintenance and disclosure of my genetic information for clinical laboratory analysis by Florida Cancer Specialists & Research Institute, LLC (FCS) and any affiliate FCS may designate to analyze my genetic information to assist in my diagnosis or treatment if determined necessary by my provider.

Benefits of NGS testing

NGS testing looks for genetic changes in my affected tissue to assist in my diagnosis or treatment. NGS testing may aid in the identification of genetic variations and mutations and the detection of cancer. Additionally, NGS testing may help your provider better determine the optimal treatment for your specific clinical needs.

Limitations of NGS testing

I understand that the test analyzes select gene regions and does not rule out the possibility of an undetected variant in a gene region not included in this test. Although genetic test results are highly accurate, several sources of error or atypical results are possible, including contamination, transfusions and bone marrow transplantations. NOTE: Please let your health care provider know if you have had a transfusion or transplant.

Disclosure of NGS test results

All tests are confidential and will be disclosed only to the ordering health care provider (or designee) and the patient unless authorized in writing by the patient or required by law. The Genetic Information Nondiscrimination Act of 2008 extends protections against genetic discrimination based on a patient's genetic information (http://www.genome.gov/10002328).
Please see www.nsgc.org or www.acmg.net for more information regarding genetic testing.

Retention of specimens

Because Florida Cancer Specialists & Research Institute, LLC (FCS) is not a storage facility, most samples are discarded 60 days following testing completion. Some samples may be stored indefinitely for test validation or research purposes after personal identifiers are removed, with the consent of the patient. Please indicate if you would like to have your sample and data retained.

I understand the above information about genetic testing, and I consent to having this testing performed. I will raise any questions about NGS testing to my provider if my provider recommends that I receive NGS testing.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____ _____
Relationship to Patient (if Authorized Representative) Date

_____ _____
Witness Date