



Kanan H. Hudhud, M.D.
A. Zakaria Hegazi, M.D.
Yun Oh, M.D.
Sebastien Kairouz, M.D.
Sadaf Taimur, M.D.
46-B Thomas Johnson Drive
Frederick, MD 21702 Suite 200
Phone: 301/695-6777
Fax: 301/695-4852

Dear New Infusion Patient,

We would like to take this opportunity to welcome you to Frederick Oncology Hematology Associates. Enclosed please find our patient registration form, financial policy, and health questionnaire. Please read carefully and complete the packet before your scheduled appointment.

Please bring these things with you to the appointment:

- **Completed new patient packet**
- **Insurance card (s) & Photo I.D**
- **Referral from primary care physician (if required by Insurance)**
- **Check or cash for co-payment**

Our staff will be happy to accommodate your needs, but we ask that you please help us by alerting the front desk or billing department of any changes to your insurance, address or phone number.

Your appointment is scheduled at:

() 205 Center Street
Mt. Airy, MD 21771

() 46 B Thomas Johnson Dr. Suite 200
Frederick, MD 21702

Infusion Date: _____ **Time:** _____

You must arrive 15 minutes prior to your scheduled time to complete all necessary paperwork. Please bring this packet to your appointment completed and present to the front desk upon arrival. If you do not arrive with packet completed you may be rescheduled.

If you can't keep your appointment, call us as soon as possible so we can reschedule.

Thanks again for choosing our practice. Call the number above at any time if we can answer any questions.

Sincerely,
Frederick Oncology Hematology Associates

Directions to our Frederick location:

From Emmitsburg, Gettysburg- take Route 15 South to Hayward Road. Make right on to Hayward Road. Then make immediate left onto Thomas Johnson Drive. We are the third building on the left, between the car wash and trailer rentals.

From Frederick City- take Route 15 North to Motter Avenue/Opposumtown Pike exit. Make right and go to third traffic light, this will be Thomas Johnson Drive. Make right onto Thomas Johnson Drive and follow for approximately one mile. We are at the end of Thomas Johnson Drive on the right side, between the car wash and trailer rentals.

From West Virginia- take 340 East to Exit 15 North to Motter Avenue/Opposumtown Pike exit. Make right and go to third traffic light, this will be Thomas Johnson Drive. Make right onto Thomas Johnson Drive and follow for approximately one mile. We are at the end of Thomas Johnson Drive on the right side, between the car wash and trailer rentals.

FREDERICK ONCOLOGY HEMATOLOGY ASSOCIATES

Name: _____ Date: _____
 Last **First** **Middle**

Address: _____ Male: _____ Female: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security #: _____ Marital Status: _____

Phone # (HOME): _____ (WORK): _____ (CELL) _____

Employer: _____

Business Address: _____

In Case of Emergency Contact: _____ Relation: _____

Phone # (Home): _____ (Work): _____ (Cell): _____

Address: _____

Referred By: _____ Family Physician: _____

INSURANCE INFORMATION

Policy Holder Name: _____ **Policy Holder SS Number:** _____

Policy Holder Date of Birth: _____ Is the policy through an employer? YES NO

Address: _____

Primary Insurance Company: _____ Phone #: _____

Policy or ID #: _____ Group #: _____

Address: _____

Secondary Insurance Company: _____ Phone #: _____

Policy or ID # _____ Group #: _____

Address: _____

REMINDER: PLEASE CALL YOUR INSURANCE COMPANY TO VERIFY COVERAGE.

I, _____ hereby certify that the above information is accurate. I agree to notify you of any change in insurance, address or phone number.

Signature: _____ Date: _____

**FREDERICK ONCOLOGY HEMATOLOGY ASSOCIATES, P.C.
FINANCIAL POLICY**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

REFERRALS: Some managed care plans require written authorization forms from your primary care physician for each visit to Frederick Oncology Hematology Associates, P.C. It is the PATIENTS responsibility to make sure that a valid authorization form is obtained BEFORE each visit. THESE FORMS CAN NOT BE ISSUED RETROACTIVELY.

1. Insurance is a contract between YOU and YOUR INSURANCE COMPANY. For the most part, we are NOT a party to this contract. We will inform you if we are a party to this contract, and will handle your claims according to our agreement with the insurance company. We file insurance claims as courtesy to our patients. We will not become involved in a dispute between you and your insurance company regarding deductible, co payments, covered charges, secondary insurance, "usual & customary charges," etc. other than to supply information as necessary. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.
2. **COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** If it becomes necessary to send you a bill for a co payment, there will be a **\$15.00 processing fee.** If you have any questions regarding your office visit co-payment, please contact your insurance company.
3. **RETURNED CHECKS** will be charged a **\$25.00 processing fee.**
4. **If you do not have insurance, an initial payment of \$287.96 is due at time of service unless prior arrangements have been made.** For minor patients, the adult accompanying a minor (even in the case of a divorce) will be responsible for payment at the time services are rendered. We will not bill a different party.

WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEY ORDERS
(Visa, MasterCard, Discover and American Express)

We would like to thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I authorize the release of any medical information necessary to process my insurance, or to another physician or medical facility if appropriate to expedite my medical care. I allow fax transmittal of my medical records, if necessary. I request payment of authorized Medicare/Insurance benefits be made to Frederick Oncology Hematology Associates, P.C. on my behalf, for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurance agencies, any information needed to determine benefits payable for related services.

I understand that I am financially responsible for all charges whether or NOT paid by insurance. If full payment is not made with regard to bills for services rendered, I agree to pay all necessary and reasonable costs of collection beginning at 27% of account balance. Including, but not limited to Attorney's fees on the balance outstanding at the time this matter is turned over to an attorney or collection agency for collection, and/or court costs. I agree to this provision.

I agree to accept all Financial Responsibility for services rendered!

Signature _____ Date _____
Patient/Guardian

Relation to Patient _____

Frederick Oncology Hematology Associates

CLEAN CLAIM GUIDELINES

I understand that by providing Frederick Oncology Hematology Associates complete and accurate information as requested, I am complying with the "Clean Claim Guidelines". "Clean Claim Guidelines" state that I must provide my name, date of birth, social security number and complete address to the provider of service in order for the provider to bill my insurance company. If any information is refused or omitted by me, I understand that I am liable for payment for the services provided.

Printed name of Patient, Guardian, or Guarantor

Signature of Patient, Guardian, or Guarantor

Date

FREDERICK ONCOLOGY HEMATOLOGY ASSOCIATES

BRIEF MEDICAL HISTORY

Medical History: please check all that apply (if yes, explain below)

- | | | |
|--|---|--|
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> GI Disease |
| <input type="checkbox"/> Mental Illness/Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding |

Tendencies

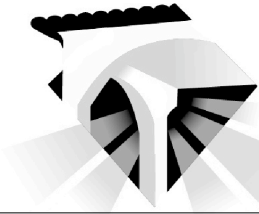
- | | |
|---|--|
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Drug/Alcohol use | <input type="checkbox"/> Other |

Explanation:

Allergies: Medications Yes No
If yes, specify drugs:

Food Allergies: Yes No
If yes, specify drugs:

Current Medications and Doses:



CANCER CARE CENTER OF ♦ FREDERICK

Frederick Oncology/Hematology Associates, PC

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The Cancer Care Center & Infusion Centers of Frederick and Mt. Airy have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.
