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 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)**
- **Referral from primary care physician (if required by Insurance)**
- **Films from X-rays, CT scans, PET scans, MRI's and mammograms**
- **Any lab test results and medical records**
- **List of current medications**
- **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:

( )46 B Thomas Johnson Frederick, MD 21702	( ) 205 Center Street Mt. Airy, MD 21771	( ) 123-126 West Main St. Emmitsburg, MD 21727

Your appointment is scheduled with Dr. ______________________at __________am/pm on____________.

You must arrive 30 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.

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

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

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

□ Home Telephone__________________
□ OK to leave message with detailed information
□ Leave message with call-back number only

□ Written Communication
□ OK to mail to my home address
□ OK to mail to my work/office address
□ OK to fax to this number

□ Work Telephone____________________
□ OK to leave message with detailed information
□ Leave message with call-back number only

□ Other____________________________
____

____
Patient Signature

____
Date

____
Print Name

____
Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	**Disclosed to Whom Address and Fax Number**	**(1)**	**Description of Disclosure/ Purpose of Disclosure**	By Whom Disclosed	**(2)**	**(3)**

CANCER CARE CENTER
FREDERICK ONCOLOGY HEMATOLOGY ASSOCIATES, P.C.
Kanan 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
P :(301) 695-6777 F :(301) 695-4852

MEDICAL RECORD RELEASE

Date: ________________

Patient Name: ________________________________ DOB: _________________

TO: ____
____
____
____

I, hereby, authorize you to release all my records, specimens and lab results to:

Frederick Oncology Hematology Associates, P.C.
46 B Thomas Johnson Drive Suite 200
Frederick, MD 21702

PLEASE FAX ALL MEDICAL INFORMATION CHECKED BELOW TO:
(301) 695-4852

( ) **RECENT** History & Physical or Physician notes
( ) **ALL** Operative/Procedure notes & Discharge summary
( ) **RECENT** Progress Notes
( ) **ALL** X-ray, CT scan, MRI, Mammogram & Ultrasound reports
( ) **ALL** Pathology reports
( ) **ALL** lab work to include CBC, Tumor Markers, etc.
( ) **ALL** Chemotherapy/Radiation records
( ) **Other:**

This authorization is valid from date: ___________________to____________________.

Patient Signature: ____________________________________ **Date:** _____________

Witness: ____ **Date:** ___________

Frederick Oncology Hematology Associates, P.C.
46 B Thomas Johnson Drive Suite 200
Frederick, MD 21702
T: (301) 695-6777

Patient Name: ______________________________ Age: _______ Birthdate: ___________

Occupation: __________________________________ Birthplace: _____________________

Martial Status: S M W D Sep

Phone number we may use to reach you for appointments, lab results, etc: __________________

HOME: ____________________________ WORK: __________________________________

Emergency Contact: ____________________________

Relationship: __________________________________ Phone Number: __________________

List the type of work you do for a living.

Do you have:			
	An advanced directive?	YES	NO
	A living will?	YES	NO
	A Durable or Medical Power of Attorney	YES	NO

Would you like information on advanced directives? YES NO

In the space below, briefly explain why you are coming to Frederick Oncology Hematology Associates and give a brief history of your current problem:

Have you been seen by other health care providers for this problems?

If so, whom? ____

What has been done and when? ____

NAME: ______________________________________ DATE OF BIRTH: ____________________________

REVIEW OF SYSTEMS

DO YOU HAVE ANY SIGNIFICANT? (CHECK ONE OR DESCRIBE)

GENERAL: ☐ Weight Loss/Gain ☐ Fevers ☐ Night Sweats
☐ Other: ____

EYES: ☐ Change in Vision
☐ Other: ____

EARS: ☐ Decrease Hearing ☐ Ear Pain
☐ Other: ____

NOSE: ☐ Sinus Problems ☐ Allergies
☐ Other: ____

THROAT: ☐ Frequent Sore Throats ☐ Persistent Hoarseness
☐ Other____

NECK: ☐ Frequent Neck Pain ☐ Arm Numbness, Tingling ☐ Thyroid Problems
☐ Other: ____

BACK: ☐ Frequent Back Pain ☐ Leg Pain, Numbness
☐ Other: ____

RESPIRATORY: ☐ Chronic Cough ☐ Wheezing ☐ Shortness of Breath
☐ 0ther:____

CARDIOVASCULAR: ☐ Exertional Chest Pain ☐Palpitations ☐ Swelling of Legs
☐ Other: ____

GASTROENTEROLOGIC: ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn
☐ Blood or pain w/BM
☐ Other: ____

GENITOURINARY: ☐ Urinary Problems☐ Menstrual Problems ☐ Sexual Problems
☐ Other: ____

NEUROLOGIC: ☐ Severe Headaches ☐ Dizzy Spells ☐ Seizures
☐ Other: ____

MUSCULOSKELETAL: ☐ Unusual Joint Pains ☐ Unusual Muscle Pains
☐ Other: ____

DERMATOLOGIC: ☐ Skin Lesions ☐ Rashes
☐ Other: ____

HEMATOLOGIC: ☐ History of Anemia ☐ Clotting Disorder ☐ Sickle Cell
☐ Other: ____

ENDOCRINOLOGIC: ☐ Unusual Thirst ☐ Cold or Heat Intolerance ☐ Discharge from Breasts
☐ Other: ____

PYCHOLOGIC: ☐ Depression ☐ Anxiety ☐ Other: ________________________________

FAMILY HISTORY

	Living	Deceased	Age	Illnesses
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Siblings				
Children				

PERSONAL HISTORY

Childhood Illnesses

Measles YES NO
Mumps YES NO
Chicken Pox YES NO
Other YES NO
Please Explain: _________
____

Adult Illnesses

Diabetes YES NO
High blood pressure YES NO
Heart problems YES NO
Respiratory problems YES NO
Mental illness YES NO
Depression YES NO
Other YES NO
Please Explain: ______________
____

Surgery

Tonsillectomy YES NO
Appendectomy YES NO
Hysterectomy YES NO
Including ovaries YES NO
Hernia surgery YES NO
Gall bladder surgery YES NO
Other: _____________________
____

Allergies

Medications: YES NO
If so, specify drugs: _______
____
____
____
Food Allergies: YES NO
Animal Allergies: YES NO
Please Explain: ____________
____

Injuries

Have you had any broken bones
or significant accidents? YES NO
Please Explain: ____________
____

Weight:

Now: ______ One year ago ______
Maximum: _______ When: ______

Height: _________

Immunizations

Pneumovax YES NO
When: ______________
Tetanus YES NO
When: ______________
Hepatitis B YES NO
When: ______________
Flu Vaccine YES NO
When: ______________
Others: YES NO
Please Explain: _________
____
____

Medications

Please list all medications (including vitamins and hormones) you are currently taking, dosage and frequency:
____
____
____
____
____
____
____
____

Have you ever been tested for

Tuberculosis: YES NO
If so, when? ______________
Results: _________________

Habits

Do you exercise regularly? YES NO
How often: ________________________
Do you smoke? YES NO
How much? ______________________
How many years? _________________
Did you ever smoke? YES NO
How many years? _________________
Do you chew tobacco/snuff? YES NO
How often? ______________________
How many years? _________________
Regular self breast exams: YES NO
Do you drink alcohol? YES NO
Rarely Moderately
Daily Never
How many drinks in a week? __________
Have you ever been treated for chemical Dependency? YES NO
Is your diet well balanced? YES NO
Fat Intake: Light Moderate Heavy
Caffeine Intake: Light Moderate Heavy
How much coffee/tea in a day? _________
How much cola in a day? ______________

Women ONLY

Menstrual history:
Age at onset: ______________
Regular: YES NO
Cycle: Every _____ days
Usual duration: ______ days
Heavy Medium Light
Pain or cramps YES NO
First day of LMP: ___________
Date of last Pap smear: _______
Ever taken estrogen? YES NO
How long? ________________
Have regular mammos? YES NO
Date of last mammo? __________

Pregnancies

How many? _________
How many live births? _________
How many miscarriages? _______
Complications? YES NO
What type? __________________
____
Age at first term pregnancy? _______

FOR PHYSICIAN USE ONLY

(Check if negative, circle if positive)

CONS:	NEGATIVE except: weight change, weakness, fatigue, fever, malaise
INTEG:	NEGATIVE except: rash, lumps, color chg, breast mass, nipple dischg
EYES:	NEGATIVE except: visual disturbances, pain, tearing, drainage, redness
EARS:	NEGATIVE except: tinnitus, earache, discharge, poor hearing
ENMT:	NEGATIVE except: sore throat, lesions, hoarse, epistazis, nasal congest.
CARDIAC:	NEGATIVE except: murmur, orthopena, edema, chest pain, palpitations
RESPIRATORY:	NEGATIVE except: dyspnea, cough,sputum, hemoptysis, wheeze, bronchitis
GI:	NEGATIVE except: n/v, chg bowel habits, bleed,pain, jaundice, GERD
GU:	NEGATIVE except: freq., nocturia, pain, hematuria, incont., stones, infxn
GYN/REPROD:	NEGATIVE except: dischg, std, pain/mass, ↓libido, [dysmenor., abn bleed]
HEM/LYMPH:	NEGATIVE except: anemia, bruising, transfusions, bleeding, claudication
MUSC/SKEL:	NEGATIVE except: weakness, arthritis swelling, stiffness, cramps, edema
NEURO:	NEGATIVE except: blackouts, seizures, weakness, parasthesias, memory loss
PSYCH:	NEGATIVE except: anxiety, depression, abnormal mood
ENDO:	NEGATIVE except: polydypsia, thyroid problems, polyphagia
COUNSEL:	safe sex, seat belts, cholesterol, BSE(F)/TSE(M), alcohol, sig./occult blood calcium/hrt, advanced directive

CANCER CARE CENTER

OF ◆ FREDERICK

Frederick Oncology/Hematology Associates, PC

Kanan H. Hudhud, MD
A. Zakaria Hegazi, MD
Yun Oh, MD
Sebastien Kairouz, MD
Sadaf Taimur, MD

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**.