Tennessee Valley Gynecologic Oncology

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Welcome new patient,

We hope the following information is helpful as you begin your journey with our practice. We've found our staff can best meet your needs if you understand how our office functions. Your unique needs are best met by understanding the active role you will take in your care.

RETURN VISIT FORM: Please help us individualize your care by filling out our return visit form at all follow-up appointments. This form helps us to identify areas of your health that need to be addressed.

CALLS TO THE NURSE: When calling the office to speak with the nurse, you may be asked to leave a message as our nurses are in clinic Monday through Thursdays from 8 a.m. to 5 p.m. Messages are checked throughout the day. Medical questions and concerns will be addressed in a timely manner. Calls made after hours will be answered by the answering service, and the provider on call will return emergency calls in a timely manner.

PRESCRIPTIONS: When calling the office for a refill on your medication, it may take up to 48 hours for your refill to be approved by your physician and called in to your pharmacy. For safety reasons, our office does not refill medications prescribed by other physicians. We do not refill narcotic prescriptions after office hours. *Please note we have a 48-hour refill prescription policy.*

DIAGNOSTIC TESTS AND PROCEDURES: Routine tests (such as mammograms) should be ordered by your primary care physician. Tests ordered by TVGO (diagnostics, biopsies, pap smears, etc.) will be scheduled for you by our office. We will call you with the date, time and any specific test instructions. You should receive your test results within 10 working days. If you have not received your results after 15 working days, please call our office for your results.

Enclosed you will find the following forms: Patient Information, Patient Family History, Review of Systems, Health Information Access and an Authorization for Disclosure.

We ask that you complete all of the enclosed forms before your first visit. This information provides critical facts about you, as well as a detailed cancer history of your family. All of this information is taken into consideration as we plan a course of action for you. We also ask that you provide a picture ID, any appropriate insurance cards and a list of all current medications to your first visit.

Thank you for allowing us to be a part of your care!

Your TVGO Team

Blackwell Medical Tower
201 Sivley Road, Ste. 620
Huntsville, AL 35801
o: (256) 265-4600
f: (256) 265-4651
huntsvillehospital.org/tvgo

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PATIENT INFORMATION

Please print Date _____

Patient's Name _____ Referred By_____
Last First MI

Address_____ City _____ State _____ Zip _____

Home Phone_____ Work Phone _____ Cell Phone _____

SS# _____ - _____ - _____ Sex: M F D.O.B _____ / _____ /_____

E-Mail Address _____

Patient's Occupation _____ Employer _____

Spouse's Name _____ Spouse's D.O.B. _____ / _____ / _____ Spouse's SS# _____ - _____ - _____

Employer's Address _____ Employer's Phone ( ) _____

Notify in case of emergency _____ Relationship _____

City _____ State _____ Phone ( ) _____

If patient is a minor, list the persons other than responsible party above, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

Person responsible for this account _____ Phone ( )_____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles, and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection. I will be responsible for all collection fees, court costs, and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH physician care concerning my illness, treatment, and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature _____ Date _____ Time _____

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Review of Systems

Do you smoke? □ Yes □ No

How much do you smoke a day? _____

Do you use alcohol? □ Yes □ No

Have you been tested for HIV? □ Yes □ No

Date and Reults : _____

REVIEW OF SYSTEMS	(please check all that apply to you)				
General	□ Normal	□ Weight Change >10 lb	□ Fatigue	□ Frequent sweats/Hot flashes	
Eyes	□ Normal	□ Change in Vision			
Ears / Mouth	□ Normal	□ Problems Hearing	□ Mouth Sores	□ Persistent Sore Throat	
Cardiovascular	□ Normal	□ Chest Pain/Tightness	□ Shortness of breath with exercise	□ Shortness of breath in bed	
Respiratory	□ Normal	□ Shortness of breath	□ Wheezing	□ Respiratory Infection	□ Head Cold
		□ Sore Throat	□ Seasonal Allergies		
Gastrointestinal	□ Normal	□ Frequent Nausea/Vom	□ Frequent Diarrhea	□ Black/Bloody Stool	
Genital	□ Normal	□ Abnormal Bleeding	□ Vaginal Discharge	□ Breast Pain/Lumps	
Urinary	□ Normal	□ Blood in Urine	□ Pain in Urination	□ Urinary incontinence	□ Urinary Hesitancy
Reproduction	□ Normal	□ Painful Intercourse	□ Bleeding after intercourse	□ Lack of Sexual Desire	
Musculoskeletal	□ Normal	□ Muscle Weakness	□ Arthritis		
Skin	□ Normal	□ Persistent Rash	□ Ulcers		
Neurological	□ Normal	□ Seizures	□ Numbness	□ Tingling	□ Syncope/Pass Out
Psychiatric	□ Normal	□ Depression	□ Anxiety		
Hematology	□ Normal	□ Easy Bruising	□ Spontaneous Bleeding	□ Enlarged Lymph Nodes	

HealthCare Screenings Tests: (please list date and place of test)

PAP Test: _____ Mammogram: _____

Bone Density: _____ Colorectal Screen: _____

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PATIENT FAMILY HISTORY INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE PLACE A CHECK MARK √ IN THE BOXES BELOW FOR YOURSELF AND FOR EACH FAMILY MEMBER WHO HAS COLON, ENDOMETRIAL, BREAST OR OVARIAN CANCER.
(Age refers to you or your family's age when the cancer was diagnosed)

	OVARIAN CANCER	**ENDOMETRIAL CANCER**	**COLON CANCER**	**BREAST CANCER**	**OTHER CANCER**
	Age of diagnosis	Age of diagnosis	Age of diagnosis	Age of diagnosis	Type & Age of diagnosis
YOURSELF					
MOTHER					
FATHER					
SISTER (S)					
BROTHER (S)					
DAUGHTER(S)					
SON (S)					
MOTHER'S SIDE					
GRANDMOTHER					
GRANDFATHER					
AUNT (S)					
UNCLE (S)					
COUSIN (S)					
NEICE/NEPHEW					
FATHER'S SIDE					
GRANDMOTHER					
GRANDFATHER					
AUNT (S)					
UNCLE (S)					
COUSIN (S)					
NEICE/NEPHEW					

ARE YOU OF ASHKENAZI JEWISH DESCENT: □ YES □ NO

DO YOU HAVE MALE RELATIVES WITH BREAST CANCER: □ YES □ NO

CONSIDER FURTHER EVALUATION FOR A HEREDITARY CANCER SYNDROME IF:

- COLON OR ENDOMETRIAL CANCER DIAGNOSED BEFORE AGE 50
- TWO FIRST DEGREE RELATIVES WITH COLON OR ENDOMETRIAL CANCER AT ANY AGE
- TWO OR MORE RELATIVES WITH BREAST CANCER BEFORE AGE 50
- ASHKENAZI JEWISH DESCENT AND ANY CASES OF BREAST CANCER BEFORE AGE 50 OR OVARIAN CANCER AT ANY AGE
- ANY MALE RELATIVE WITH BREAST CANCER

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132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person _____

Address _____

Fax/Phone _____

Huntsville Hospital Requests Information for the Following Patient:

Patient Name _____

SS# (Optional) _____ Date of Birth _____

Address _____

Phone _____

Signature _____ Date of Service _____

Patient Number

Requested information for treatment, payment, or operations:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ EKG Report
- ☐ Nurses' Notes
- ☐ Progress Notes
- ☐ Physicians' Orders
- ☐ Outpatient Record
- ☐ Emergency Dept Record
- ☐ Laboratory Results
- ☐ Imaging Results
- ☐ Other _____

_____

_____

_____

_____

Please send to:
Dr. Tyler Kirby
201 Sivley Road, Suite 620
Huntsville, AL 35801
(256) 265-4600
Fax: (256) 265-4656

Signature _____ Date _____

Relationship to Patient _____

Witness _____

HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin #_____

----------AUTHORIZATION TO CALL---------

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or Test results

----------HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY---------

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

----------FINANCIAL FEES AND ASSISTANCE---------

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

----------AUTHORIZATION OF TREATMENT---------

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

----------ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY ----------

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

----------HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT----------

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

----------EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE----------

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

----------FOR USE BY HEALTH SYSTEM PERSONNEL ONLY ----------

--------(Complete if patient Acknowledgment is not obtained) ----------

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____

Witness/Employee Signature: _____ Employee ID: _____

Date _____ Time _____

HUNTSVILLE HOSPITAL PHYSICIAN'S NETWORK TN VALLEY GYNECOLOGIC ONCOLOGY
101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional) _____

Date of Birth _____ Address _____

Phone Number (_____) _____Date(s) of Service_____

Chart Number_____
Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital Physician's Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ All /Entire Record	☐ Pathology Report	☐ **Records Release Format**
☐ Visit/Encounter Notes	☐ Consultation Report	**(Choose one)**
☐ Laboratory Results	☐ Operative Report	☐ **e-delivery (HealthPort Connect)**
☐ X-Ray and Imaging Reports	☐ Immunization Record	☐ **CD**
☐ Problem list	☐ Drug and Alcohol Treatment	☐ **Paper**
☐ Medication List	☐ HIV/AIDS/STD Treatment	
☐ Allergies List	☐ Registration Record	
☐ EKG Report	☐ Other _____	

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

For Office Use Only

Any portion of the record request found in paper chart? YES NO (Please circle one)