



Gynecologic Oncology
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Medical Oncology/Hematology
Norman H. Siegel, MD
Howard I. Kesselheim, DO
Carlos S. Madamba, MD
Richard H. Greenberg, MD
Kevin J. Callahan, DO
Stephen E. Zrada, MD
Yong Ji, MD
Priya P. Gor, MD

Date: _____

Dear

Welcome to The Center for Cancer and Hematologic Disease. We understand that this may be an upsetting time for you and your family. At The Center, your comfort and the quality of care that you receive are our primary concerns. We hope that you will allow us to help you in any way that we can.

Drs. Norman Siegel, Howard Kesselheim, Carlos Madamba, Richard Greenberg, Kevin Callahan, Stephen Zrada, Yong Ji, and Priya Gor are Board-Certified Medical Oncologists, Hematologists and Internists. All of these doctors are on staff at the following hospital systems: Virtua, Underwood, Kessler, Our Lady of Lourdes, Kennedy, and Cooper. The doctors are supported by Faith Weintraub, an Oncology Clinical Nurse Specialist and a Certified Advanced Practice Nurse who works closely with the Medical Oncologists.

Dr. Howard Saul is a Board-Certified Gynecologic Oncologist. Dr. Saul is affiliated with Virtua, Underwood, Our Lady of Lourdes, Kennedy, Cooper, and the South Jersey Regional Medical Center (formerly the South Jersey Hospital System).

Within our practice we have a full service laboratory and a pharmacy on-site. Our doctors and nurses can be reached 24 hours a day, seven days a week, through our answering service at (856) 424-3311.

All of us are grateful that you have chosen The Center for Cancer and Hematologic Disease to provide your care. Please visit us on the web at <http://www.centerforcancer.com>. We welcome any suggestions or creative ideas that might enhance the service we offer.

Sincerely,

Patient Relations

Your Appointment Date: _____

Your Appointment Time: _____

Office Hours

New Patient Information

Patient Name: _____

Patient Address: _____

Patient Home Phone: () _____

Patient Work Phone: () _____

Patient Email Address (if applicable): _____

Patient Date of Birth: _____

Patient Social Security Number: _____

Spouse's Name: _____

Spouse's Social Security Number: _____

Spouse's Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship: _____

Emergency Contact Address: _____

Referring Doctor Name: _____

Referring Doctor Phone Number: _____

Authorization

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or to another physician's office. I also permit a copy of this authorization to be used in place of the original. This agreement will remain in effect until revoked by me in writing.

SIGNATURE: _____ DATE: _____

Records Release Authority

TO: _____

I, _____, hereby request that you release to

*The Center for Cancer and Hematologic Disease
Executive Mews, Suites V-107 & U-99
1930 East Route 70
Cherry Hill, NJ 08003
Phone (856) 424-3311
Fax (856) 424-2945*

a report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me from _____ to _____.

(Date of Request)

(Patients Signature)

(Witness)

(Address)

(Date)

(City, State, Zip Code)

Insurance Information

Primary Insurance: _____

ID#: _____ Group#: _____

Insurance Company Address: _____

Insurance Company Phone Number: () _____

(Note: Insurance Company address and phone number are typically found on the back of your insurance card)

Subscriber: _____ DOB: _____ SS# _____

(Note: Subscriber means the name of the family member from which the policy originates)

Subscriber's Employer Name: _____

Subscriber's Employer Address: _____

Subscriber's Employer Phone Number: () _____

Secondary Insurance: _____

ID#: _____ Group#: _____

Insurance Company Address: _____

Insurance Company Phone Number: () _____

(Note: Insurance Company address and phone number are typically found on the back of your insurance card)

Subscriber: _____ DOB: _____ SS# _____

(Note: Subscriber means the name of the family member from which the policy originates)

Subscriber's Employer Name: _____

Subscriber's Employer Address: _____

Subscriber's Employer Phone Number: () _____

Do you have a prescription plan? Yes No

PATIENT RESPONSIBILITY REGARDING INSURANCE

- 1. Please notify our office immediately of any change in your insurance coverage, home address or phone number.**
- 2. Co-pays are to be paid at the time of your visit per your insurance company agreement.**
- 3. Obtaining MANAGED CARE REFERRALS from your primary physician.**
- 4. You will be responsible to submit to your secondary insurance unless it is a managed care or Medicare rollover.**

SIGNATURE: _____

DATE: _____

PHYSICIANS:

Primary/Family: _____

Radiation Therapy: _____

Surgeon: _____

Gynecology/Urology: _____

Other: _____

HISTORY OF PRESENT ILLNESS:

Why did you come to see the physician today?

1. _____

2. _____

3. _____

LIST ANY DRUGS TO WHICH YOU ARE ALLERGIC:

FAMILY HISTORY:

	LIVING			DECEASED	
	Male /Female	Age	Health	Age (at Death)	Cause
Father					
Mother					
Brother / Sister					
Spouse					
Child					
Child					
Child					
Child					

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

SOCIAL HISTORY (circle):

Yes No Do you now or have you in the past ever smoked?
Cigarettes Pipes Cigars
How long? _____ When did you stop? _____

Yes No Do you now or have you in the past ever regularly consumed alcohol?
Beer Wine Liquor
How much? _____

MEDICAL /SURGICAL HISTORY:

List all medications (prescription or over-the-counter) that you currently take:

List the names and dates of any operations which you have had:

List any health reasons that required hospitalization:	When?	What Hospital?
_____	_____	_____
_____	_____	_____

List any serious illnesses which you have had (not requiring hospitalization):

List any serious injuries or accidents:

PRINT NAME: _____

SIGNATURE: _____

REVIEW OF SYSTEMS

Do you now or have you had and problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Weight Loss	Y	N
Excessive Fatigue	Y	N
Other	_____	

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Tearing	Y	N
Other	_____	

Allergic/Immunologic

Hay Fever	Y	N
Other	_____	

Neurological

Tremors	Y	N
Dizzy Spells/Fainting	Y	N
Numbness/Tingling	Y	N
Headache	Y	N
Seizures	Y	N
Weakness	Y	N
Other	_____	

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
High Sugar/Diabetes	Y	N
Other	_____	

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion	Y	N
Diarrhea	Y	N
Bleeding	Y	N
Other	_____	

Cardiovascular

Chest Pain	Y	N
High Blood Pressure	Y	N
Palpitations	Y	N
Edema/Swelling	Y	N
Other	_____	

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Integumentary

Skin Rash	Y	N
Persistent Itch	Y	N
Hives	Y	N
Dry Skin	Y	N
Other	_____	

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other	_____	

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Hearing Loss	Y	N
Difficulty Swallowing	Y	N
Change in Voice	Y	N
Other	_____	

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Bleeding	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Bleeding	Y	N
Other	_____	

Hematologic/Lymphatic

Bruising	Y	N
Swollen Glands	Y	N
Blood Clotting Problem	Y	N
Excessive Bleeding	Y	N
Other	_____	

Gynecology

Abnormal/Irregular Bleeding	Y	N
Vaginal Discharge	Y	N
Vaginal Dryness	Y	N
Painful Sexual Relations	Y	N
Pelvic Pain/Pressure	Y	N
Hot Flashes	Y	N
Urinary Incontinence	Y	N
(Loss of Bladder Control)		
Breast (Pain/Lump/Discharge)	Y	N

Do you have, or have you ever had any of the following medical conditions?

Seizure Disorder	Yes	No	Liver Disease	Yes	No
Visual Disturbances	Yes	No	Alcoholism	Yes	No
Headaches	Yes	No	Bladder Infections	Yes	No
Chronic Diarrhea	Yes	No	Irritable Bowel	Yes	No
Kidney Disease	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No

If Diabetic, list meds:

Oral Meds: _____ Name: _____

Insulin: _____ Name & Dose: _____

Other: _____

Heart Disease	Yes	No	Heart Attack	Yes	No
Mitral Valve Prolapse	Yes	No	Heart Failure	Yes	No
Heart Surgery	Yes	No	Irregular Heartbeat	Yes	No
High Blood Pressure	Yes	No	COPD	Yes	No
Lung Disease	Yes	No	Asthma	Yes	No
Tuberculosis	Yes	No	Shortness of Breath	Yes	No
Chronic Bronchitis	Yes	No	Emphysema	Yes	No

Do you have bleeding problems? Yes No

Do you take antibiotics prior to surgery/dental work? Yes No

Other Illnesses? _____

Have you ever had surgery?

Tonsils	Yes	No	Appendectomy	Yes	No
D & C	Yes	No	Hysterectomy	Yes	No
Ovarian Surgery	Yes	No	Ovary Removed (L / R)	Yes	No
Mastectomy (L / R)	Yes	No	Lumpectomy (L / R)	Yes	No

Other: _____

Have you ever had an abnormal pap smear? Yes No

If so, when? _____ What was the abnormality? _____

What was the treatment? _____

Have you ever been diagnosed with cancer? Yes No

Have you ever had radiation treatments? Yes No

If so, when? _____

Have you ever had chemotherapy? Yes No

If so, when? _____

Have any blood relatives been treated for cancer?

Yes No

				<u>Alive</u>	<u>Deceased</u>
Breast	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Colon	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Lung	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Uterine	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Cervical	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Other (Type)	Yes	No	Relation _____	<input type="checkbox"/>	<input type="checkbox"/>

Is there any family (blood) history of:

Diabetes	Yes	No	Relation _____
Heart Disease	Yes	No	Relation _____
Strokes	Yes	No	Relation _____
High Blood Pressure	Yes	No	Relation _____
Bleeding Disorder	Yes	No	Relation _____
Other (Type)			Relation _____

The Center for Cancer and Hematologic Disease, P.A.

Contact Preferences

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* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check the boxes next to each method of communication you would like us to use:

Home

- OK to leave message
with detailed information
- Leave message with call-back number only
- OK to mail
- OK to fax

Work

- OK to leave message
with detailed information
- Leave message with call-back number only
- OK to mail
- OK to fax

Cell phone

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

Other:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. Please see the accompanying Notice of Privacy Practices for more information on our policies.

Please list any individuals among your friends, family, or caretakers with whom we are authorized to discuss your protected health information. You should write your spouse's name here if he/she is authorized. This is optional; if you do not wish us to discuss your *PHI* with anyone but yourself and your healthcare providers please leave this blank:

Name	Phone Number	Relationship

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of The Center for Cancer and Hematologic Disease, P.A.

Signature of Patient or Personal Representative

Today's Date

Print Name of Patient or Personal Representative

Patient's Date of Birth

Description of Personal Representative's Authority

The Center for Cancer and Hematologic Disease, P.A.

Notice of Privacy Practices

Effective Date: 4/14/03

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 and keep it for your records.

If you have any questions about this notice or would like further information, please contact Mercia Dona at 856-424-7983 x1300.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of protected health information, and to provide you with this Notice of Privacy Practices. We may change the terms of our Notice of Privacy Practices, at any time. Any new Notice of Privacy Practices will apply to all protected health information that we maintain as of the effective date of the new Notice of Privacy Practices. A copy of our current Notice of Privacy Practices will always be posted in our reception area. To obtain a copy of any revised Notice of Privacy Practices, please call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of protected health information we gather about you while providing health-related services. Some examples of protected health information are:

- information about your health condition (such as a disease you may have);
- information about health care services you have received or may receive in the future (such as an operation or specific therapy);
- information about your health care benefits under an insurance plan (such as whether a prescription or medical test is covered);
- geographic information (such as where you live or work);
- demographic information (such as your race, gender, ethnicity, or marital status);
- unique numbers that may identify you (such as your social security number, your phone number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Treatment, Payment, and Normal Business Operations

The physicians and other clinicians and staff members within our practice may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run the practice's normal business operations. Your health information may also be shared with affiliated hospitals and health care providers so that they may jointly perform certain payment activities and business operations along with our practice. Below are further examples of how your information may be used for treatment, payment, and health care operations.

Treatment

We may share your health information with doctors or nurses within our practice who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. For example, a doctor within our practice may share your health information with another doctor within our practice, or with a doctor at another health care institution (such as a hospital), to determine how to diagnose or treat you. A doctor in our practice

may also share your health information with another doctor to whom you have been referred for further health care.

Payment

We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. We may also share information about you with your health insurance company to determine whether it will cover your treatment or to obtain necessary pre-approval before providing you with treatment.

Business Operations

We may use your health information or share it with others in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our physicians or staff in caring for you, or to educate our physicians or staff on how to improve the care they provide for you. We may also share your health information with another company that performs business services for us. If so, we will have a written contract to ensure that this company also protects the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits and Services

We may use your health information when we contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

2. Friends and Family

In limited circumstances, we may use your health information or share it you're your friends and/or family involved in your care, without your written authorization. We will always give you an opportunity to object unless there is insufficient time because of a medical emergency (in which we will discuss your preferences with you as soon as the emergency is over) or if you are unable or unavailable to make decisions regarding your health information and the physician treating you deems the disclosure to be in your best interest. We will follow your wishes unless we are required by law to do otherwise.

If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative, or another person responsible for your care about your general condition or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Emergencies or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs as may be required by law. We will not be required to obtain your written authorization, consent or any other type of permission before using or disclosing your information for these reasons.

Emergencies

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your authorization. If this happens, we will try to obtain your authorization as soon as we reasonably can after we treat you.

Communication Barriers

We may use and disclose your health information if we are unable to obtain your authorization because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Public Health Activities

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities as required by law. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or

disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits or requires us to do so.

Victims of Abuse, Neglect or Domestic Violence

We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence as required or permitted by law. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities

We may release your health information to government agencies authorized to conduct audits, investigations, and inspection of our facility as required or permitted by law. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair or Recall

We may disclose your health information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes

We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement

We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders, subpoenas, or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct; or
- If necessary to report a crime that occurred on our property.

To Avert a Serious Threat to Health or Safety

We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

Military Activity and Nation Security

When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Inmates and Correctional Institutions

We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Workers' Compensation

Your protected health information may be disclosed by us as to comply with workers' compensation laws and other similar legally established programs.

Coroners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as required by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research

We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

1. Right to Inspect and Copy Records

You have the right to inspect and copy your health information. Please contact the Front Office Manager if you have questions about access to your medical record.

2. Right to Amend Records

You have the right to request that we amend your health information, including if you believe it is inaccurate or incomplete. Please contact the Front Office Manager if you have questions about amending your medical record.

3. Right to an Accounting of Disclosure

This right applies to disclosures of purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. Please contact the Front Office Manager to request an accounting.

4. Right to Request Additional Privacy Protections

You have the right to request further restrictions on the way we use your health information and share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement until we notify you otherwise.

5. Right to Request Confidential Communications

You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work.. We will try to accommodate all reasonable requests. Please contact the Front Office Manager with any requests or questions.

HOW TO FILE A COMPLAINT

If you have any questions or concerns about our privacy policies please contact us. In addition, if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. For questions regarding our privacy policies or to file a complaint with us, please contact our Front Office Manager at (856) 424-3311. We will not retaliate or take action against you for filing a complaint.

