CATTAIL RIVER HEMATOLOGY & ONCOLOGY
J. GARRETT REILLY, PH.D., M.D.
3418 Olandwood Court, Suite 111
Olney, MD 20832
Phone: 301-774-8198
Fax: 301-774-8199
Web: www.Cattailriver.com

PATIENT INFORMATION SHEET

PERSONAL INFORMATION Date: ______________________

Patient Name: ______________________ Male ☐ Female ☐ Marital Status: __________

Patient Social Security #: ______________________ DOB: ______________________

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Referring Physician: ______________________ Phone: ______________________

Person to contact in case of emergency: ______________________

Relationship: ______________________ Phone: ______________________

RESPONSIBLE PARTY

Responsible person for account: ______________________

Relationship: ______________________ Home Phone: ______________________

PAYMENT AUTHORIZATION

I hereby authorize and direct my insurer to issue payment for benefits due to me for services provided by Cattail River Hematology & Oncology. I further authorize the release of any medical information necessary to process my insurance claim.

I acknowledge that the insurance information provided is current and correct. I will notify the office of any changes in my insurance information at the time of service. I also acknowledge that, if needed, I am responsible for providing the office with a current referral prior to my being seen. If I fail to do so, I understand that I am financially responsible for any unpaid fees.

Regardless of my insurance benefits, I acknowledge that I am financially responsibility for any deductible, co-payment, and balance remaining after insurance has paid.

______________________________ ______________________

Signature of Patient or Guardian Date

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HEALTH HISTORY

PATIENT NAME: ______________________________ **DOB:** ____________________

To help us meet all of your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date: ____________________
Place of Birth: ____________________
Highest Level of Education: ____________________
Occupation: ____________________
Previous Occupations: ____________________
Marital Status: ____________________
Hobbies: ____________________
Habits:
Smoking (type and amount per day): ____________________
If former smoker, date quit: ____________________
Alcohol (type and amount per day): ____________________
Caffeine (type and amount per day): ____________________
Street Drugs (type and amount per day): ____________________
Usual Weight: ____________________
Date of last dental exam: ____________________
Please list all allergies (foods, drugs, environment, etc.)
____
____

When was your last physical exam? ____________________
Name of doctor: ____________________
Phone: ____________________
Please list all serious illnesses, operations, and other hospitalizations you have experienced, and indicate the year these occurred: ☐ None ____________________
____
____

Please list all medicines you are currently taking, including nonprescription drugs: ☐ None ____________________
____
____
____

List all serious accidents/ injuries, head injuries, fractures, or broken bones (include date occurred): ☐ None
____
____
____

Chief Complaints: Please list, in order of importance, the present health concerns, symptoms, or any problems you are experiencing? ____________________
____

Past Medical History: Have you ever had the following? (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Diabetes	no	yes	Stroke	no	yes
Mumps	no	yes	Cancer	no	yes	Mitral Valve Prolapse	no	yes
Chickenpox	no	yes	Polio	no	yes	Ulcer	no	yes
Whooping Cough	no	yes	Glaucoma	no	yes	Kidney Disease	no	yes
Scarlet Fever	no	yes	Hernia	no	yes	Thyroid Disease	no	yes
Diphtheria	no	yes	Blood/ Plasma Transfusions	no	yes	Bleeding tendency	no	yes
Smallpox	no	yes	# Transfusions	________		Hepatitis	no	yes
Pneumonia	no	yes	Reactions	________		Any other disease	no	yes
Rheumatic Fever	no	yes	Back trouble	no	yes	(Please List) ________		
Heart Disease	no	yes	Hemorrhoids	no	yes	________		
Arthritis	no	yes	Date of last chest x-ray	________		________		
Venereal Disease	no	yes	Asthma	no	yes	________		
Anemia	no	yes	Hives/Eczema	no	yes	________		
Bladder Infections	no	yes	Aids/HIV+	no	yes	________		
Epilepsy	no	yes	Infectious Mono	no	yes	________		
Migraine Headaches	no	yes	Bronchitis	no	yes	________		
Tuberculosis	no	yes	High/Low blood pressure	no	yes	________		

Family History: If living, please list the present age and health (good, fair, poor) of the following family members. If deceased, please list cause of death, and the age of death.

Mother: ____________________
Father: ____________________
Siblings: ____________________
____

Spouse: ____________________
Children: ____________________
____
____

Family History: Has any blood relative had any of the following? (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes	___	Mental Illness	no	yes	___
Leukemia/Lymphoma	no	yes	___	Stroke	no	yes	___
Tuberculosis	no	yes	___	Epilepsy	no	yes	___
Diabetes	no	yes	___	Allergies	no	yes	___
Heart Disease	no	yes	___	Anemia	no	yes	___
High Blood Pressure	no	yes	___	Bleeding Tendency	no	yes	___
Asthma	no	yes	___	Blood Clots	no	yes	___
Chronic Lung Disease	no	yes	___	Gout	no	yes	___
Drug/Alcohol Abuse	no	yes	___	Obesity	no	yes	___
Migraine Headaches	no	yes	___	Thyroid Disease	no	yes	___
Ulcer	no	yes	___	Depression	no	yes	___
High Cholesterol	no	yes	___	Kidney Disease	no	yes	___

Current Conditions: Do you currently have, or have had within the past year? (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes	Lump/discharge from breast	no	yes	Hemorrhoids	no	yes
Tire easily or weakness	no	yes				Joint pair or swelling	no	yes
Weight gain	no	yes	Shortness of breath	no	yes	Backaches	no	yes
Weight loss	no	yes	Bloody sputum	no	yes	Swollen Joints	no	yes
Loss of appetite	no	yes	Wheezing	no	yes	Muscle cramps/spasms	no	yes
Sensitivity to cold or heat	no	yes	Chest pain/discomfort	no	yes	Easy bruising	no	yes
Persistent fever	no	yes	Purple fingers/lips	no	yes	Lack of sex drive	no	yes
Night sweats	no	yes	Swelling of hands/feet	no	yes	Sleeplessness	no	yes
Skin rash	no	yes	Difficulty breathing	no	yes	Seizures	no	yes
Skin trouble or changes	no	yes	Palpitations/fluttering of the heart	no	yes	Depression	no	yes
Change in nails/hair	no	yes				Memory loss	no	yes
Headaches	no	yes	Leg cramps	no	yes	Poor Coordination	no	yes
Double vision	no	yes	Enlarged veins	no	yes	Dizziness/Fainting	no	yes
Blurred vision	no	yes	Difficulty swallowing	no	yes	Prolonged bleeding when cut	no	yes
Eye pain	no	yes	Frequent belching	no	yes			
Infected eye	no	yes	Heartburn	no	yes	Living will/advanced directives	no	yes
Usage of glasses/contacts	no	yes	Abdominal cramping	no	yes			
Last eye exam ___			Nausea	no	yes	**Women Only:**		
Ringing in ears	no	yes	Vomiting	no	yes	Age period began: ___		
Discharge from ears	no	yes	Vomited/Coughed blood	no	yes	Bleeding/spotting between periods	no	yes
Decrease in hearing	no	yes	Chronic diarrhea	no	yes			
Frequent nosebleeds	no	yes	Chronic constipation	no	yes	Pain/Cramps	no	yes
Frequent colds	no	yes	Rectal bleeding	no	yes	Date of last period: ___		
Sinus troubles	no	yes	Black tarry stools	no	yes	Date of last pelvic exam: ___		
Loss of smell	no	yes	Yellow jaundice	no	yes	Date of last mammogram: ___		
Persistent hoarseness	no	yes	Increase in thirst	no	yes	Vaginal itching	no	yes
Sore throat	no	yes	Frequent urination	no	yes	Pain w/intercourse	no	yes
Sore tongue/gums	no	yes	Painful urination	no	yes	Birth Control Type: ___		
Persistent cough/throat clearing not associated w/an illness lasting more than 3 weeks	no	yes	Leakage of urine	no	yes	Number of pregnancies: ___		
			Difficulty starting urine	no	yes	Number of full-term births: ___		
			Dark/tea-colored urine	no	yes	Number of pre-term births: ___		
			Blood in urine	no	yes	Did you breast-feed?	no	yes
						Age of first child birth: ___		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

___ Signature of patient or patient minor

___ Date

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NOTICE OF MEDICAL PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment:** Providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical exam.
- **Payment:** Activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and stylization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations:** Activities including the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with request to protected health information. This notice is effective as of April 4, 2003, and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information. For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

In addition, I hereby authorize the following people to obtain my medical information and/or discuss my medical condition:

______________________________ Date of Birth: ________________

______________________________ Date of Birth: ________________

Patient Name: ________________________ Date: ____________________

Signature: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below.

Date:	Initials:	Reason: