HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

PATIENT PERSONAL INFORMATION

Please print legibly. Date: ..... / ..... / .....

Name (full legal): .....

Address: ..... Apt.#: .....

City: ..... State: ..... Zip: .....

Sex: ☐ Male ☐ Female Birth date: ..... / ..... / .....

Home Phone: (.....) ..... - ..... Cell Phone: (.....) ..... - .....

Email address (use BLOCK letters): .....

Soc. Sec. #: ..... - ..... - ..... Occupation: .....

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Long term partner ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ Caucasian ☐ Black ☐ American Indian ☐ Asian ☐ Hispanic ☐ Other

Employer: .....

Address: .....

City: ..... State: ..... Zip: .....

Phone: (.....) ..... - ..... Ext: ..... Can we call you at work? ☐ Yes ☐ No

Emergency Contact: .....

Address: .....

City: ..... State: ..... Zip: .....

Relation: ..... Home Phone: (.....) ..... - .....

Work Phone: (.....) ..... - ..... Cell Phone: (.....) ..... - .....

HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

Current medical problem:

Diagnosis: .....

Referred by Dr.: .....

Surgery done ☐ Yes ☐ No Dr.....

Chemotherapy dates: ..... Dr. .....

Hormone therapy dates: ..... Dr. .....

Other treatment (s): ..... Dr. .....

Current symptoms or difficulties (Today) .....

.....

Recent xray - CT scan - MRI - PET/CT scan - other

Date: ..... @ .....

Date: ..... @ .....

HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

MEDICAL HISTORY FORM

Please print legibly.

Primary Care Physician: Name: .....
Address: .....
Phone: .....

Referring Physician: Name: .....
Address: .....
Phone: .....

Do you: Smoke? ..... Packs per day ..... Years smoked ..... When did you quit? .....
Drink Alcohol? ..... Drinks per week # .....
Drink Cola/Coffee? ..... How much per day? .....

List the medications you are now taking:

.....
.....
.....

List any allergies you have to drugs, food or other items:

.....

List all Operations:

Operation Performed	Year	Hospital	Doctor
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

List all stays in hospital (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Please list all medical problems you have / had and dates:

.....
.....
.....

Please list all family medical history including cancer:

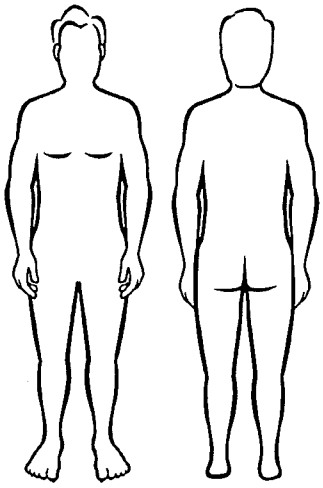
.....
.....

HYDE PARK CANCER CENTER

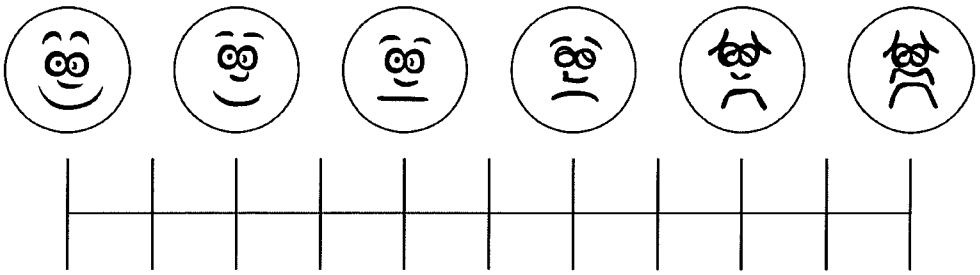
WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

MEDICAL HISTORY FORM

DO YOU HAVE ANY PAIN?
PLEASE MARK ON THE PICTURE WHERE THE PAIN IS LOCATED AND HOW BAD?



PAIN SCALE



ADDITIONAL INFORMATION:
FOR WOMEN:

AGE AT FIRST MENSES		AGE AT LAST MENSES	
NUMBER OF PREGNANCIES		NUMBER OF LIVE BIRTHS	

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR BREAST?
NIPPLE DISCHARGE ....., TENDERNESS ....., MASSES ....., FIBROBLASTIC DISEASE .....
DATE OF LAST MAMMOGRAM ....., DO YOU DO BREAST SELF-EXAMS? YES ..... NO .....

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Print Name of Witness: _____

Signature of Witness: _____

Date: _____

HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

MEDICAL HISTORY REVIEW OF SYSTEMS

Ⓨ Ⓝ

Allergic/Immunologic
O O frequent colds
O O HIV risk factors
O O seasonal allergies/hay fever
O O hx. of organ transplant
O O taking Chemotherapy in last 3-6 mo
O O year-round allergies
O O other - please explain

Constitutional
O O chills
O O fatigue
O O fever
O O night sweats
O O weight gain (unintentional)
O O weight loss (unintentional)
O O other - please explain

Ears, Nose & Throat
O O ear pain
O O hearing problems
O O nasal congestion
O O non-healing nasal ulcer
O O runny nose (frequent)
O O sore throat
O O tooth pain
O O hoarseness
O O dentures
O O dry mouth/metallic taste
O O chronic sore tongue
O O difficulty swallowing
O O severe hearing loss
O O other - please explain

Endocrine
O O hair loss
O O heat/cold intolerance
O O excessive body hair growth
O O infertility
O O excessive thirst
O O excessive hunger
O O excessive sweating
O O other - please explain

Eyes
O O blurred vision
O O eye pain
O O glasses/contacts
O O eye drainage

Ⓨ Ⓝ

Heart and Circulation
O O chest pain
O O dizziness
O O palpitations/irregular heart beat
O O ankle and leg swelling
O O varicose veins
O O swelling of feet/ankles
O O episodes of fast heart rate
O O any heart defect

Lungs and Breathing
O O cough (chronic)
O O shortness of breath
O O exposure to TB
O O coughing up blood
O O wheezing
O O other - please explain

Gastrointestinal
O O abdominal pain
O O acid reflux/heartburn
O O loss of appetite
O O nausea
O O vomiting
O O bloating
O O pain with swallowing
O O constipation
O O diarrhea
O O hemorrhoids
O O tarry or clay colored stool
O O other - please explain

Genitourinary
O O painful urination
O O blood in urine
O O frequent urinary tract infections
O O up at night to urinate
O O urinary incontinence
O O urine stream change
O O flank pain
O O genital lesions
O O unprotected intercourse
O O impotence/problems with erections (male)
O O other - please explain

Ⓨ Ⓝ

Musculoskeletal
O O back pain
O O joint aches
O O joint pain
O O joint stiffness
O O muscle pain
O O muscle aches
O O muscle stiffness
O O problems walking

Neurological
O O dizziness
O O fainting
O O headaches
O O memory loss
O O seizures
O O vertigo
O O stroke
O O paralysis
O O speech change
O O limited motion
O O other - please explain

Psychiatric
O O anxiety
O O depression
O O feeling stressed
O O personality change
O O recreational drug use
O O sleep disturbance
O O suicidal thoughts
O O other - please explain

Skin/Breasts
O O acne
O O mole(s) that concern you
O O yellowing of skin or eyes
O O excessive itching
O O rashes
O O wart(s)
O O breast tissue sensitivity
O O breast tissue changes
O O breast mass
O O self-breast exams (female)
O O other - please explain

HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

REQUEST FOR RELEASE OF MEDICAL RECORDS

I, hereby authorize

to furnish the following medical information and records: (check all that apply):

☐ The patient's medical record and/or imaging studies and reports, including:

Outpatient Referral **Discharge Summary** **Clinical History**

Radiology studies X Ray, CT, MRI, etc ... **Recent Laboratory Reports** **Pathology Reports**

Operative Reports

☐ Medical information as related to: .....

☐ Records dated: ..... ☐ Other: .....

for the purpose of: .....

Records to be sent to:

Hyde Park Cancer Center
601 S. Armenia Avenue
Tampa, Florida 33609
Phone: 813-353-8803
Fax: 813-353-8602

In addition to the information listed above, I authorize the release of the following *(initial if appropriate)*:

☐ Diagnoses and/or treatment for alcohol and/or drug abuse .....

☐ Psychiatric or psychotherapeutic records .....

☐ Sexually transmissible disease and HIV test results .....

My refusal to sign this Authorization will not affect my ability to obtain treatment or payment. This authorization will remain in effect until: .....

I understand that information released may be subject to redisclosure by the recipient. I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the practice has already taken action in reliance on my authorization.

.....
Print Name of Patient

....
Signature of Patient or Legal Representative Date

....
Legal representative, print name Relationsbip to Patient

HYDE PARK CANCER CENTER

WILLIAM ASSAD, M.D.
601 S. Armenia Ave.
Tampa, FL 33609
Phone: (813) 353-8803
Fax: (813) 353-8602

CONSENT FOR PATIENT PHOTOGRAPHY

(Medical Care Documentation)

I understand that photographs may be recorded of my treatment site(s) for medical care documentation; and I consent to this. I understand that Hyde Park Cancer Center will retain the ownership rights to these photographs and that they will be filed as a permanent part of my medical record for the time period required by law or outlined in Hyde Park Cancer Center policy. Images that identify me will be released only upon written authorization from me or my legal representative.

.....
Print name of Patient or legal Representative

....
Signature of Patient or legal Representative Date

....
Witness Date

Florida Urology Partners
Dr. William Assad

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or workers Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a healthcare plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-In logs may be disclosed to verify office visits.
- Occasional photographs and other letters and cards of appreciation from patients that are displayed.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: **Jody Rodriguez** and can be reached at **813-356-0196**
- Inspect copy and amend your protected health information and amend it as allowed by law.
- To render a complaint to our privacy officer or the secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.
Name of Patient (print) _____
Signature of Patient/Legal Representative_____
Date_____

Revised January 2, 2013

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patients Information:

Name: _____ Date of Birth: _____

Last 4 digits of social security #_____

I authorize and request Florida Urology Partners to receive copies of medical records from any Physicians Office, Laboratory and/or Hospital that has any health information on me. The information that is being requested is needed as soon as possible in order to get the proper medical treatment I need at the time services are rendered.

Medical Records are being requested at this time from

_____
_____
_____

Patients Name (print) _____
Signature of Patient/Legal Guardian_____
Date_____

Medical records need to be faxed to **813-353-8602**. If access to fax information is not available, please mail medical records to:
Hyde Park Cancer Center
601 S. Armenia Ave.
Tampa, FL 33609

Persons Authorized to Receive Information:

Health information Florida Urology Partners collects or receives about you may be disclosed to the following persons:

Name of Person relation/organization

Name of Person relation/organization

Name of Person relation/organization

Use and disclosure of Information:

___I authorize the person/organization for the above to receive all health information about appointments, treatments and/or other information pertinent to my health care and/or payments for my health care provided at the office of **Dr. William Assad**

___I do not authorize the following information to be disclosed to any other parties except to me, as the patient:

601 S. Armenia Ave. Tampa, FL 33609

HP HYDE PARK
CC CANCER CENTER

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: .....

Patient Name: ..... (.....) .....
Last *First* *M.I.* *Home Telephone*

Home Address: ..... **Mailing Address** .....
Street *Street*

....
City *Street* *Zip* *City* *State* *Zip*

DOB: ..... **Age:** ..... ☐M ☐F **SS#** ..... ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed** ☐**Other**
Sex *Check Marital Status*

Employer: ..... (.....) .....
Name *Telephone*

.....
Address *Occupation*

Responsible Party: ..... (.....) .....
Name *Relationship* *Telephone*

Emergency Contact:
Spouse/Next of Kin: ..... (.....) .....
Name *Relationship* *Telephone*

Referring Physician: ..... **Primary Care Physician:** .....

Primary Ins: ..... **Telephone ( )** .....
Insured Name: ..... **DOB:** ..... **Group #:** ..... **Policy #:** .....
Secondary Ins: ..... **Telephone ( )** .....
Insured Name: ..... **DOB:** ..... **Group #:** ..... **Policy #:** .....

---

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Hyde Park Cancer Center (HPCC). I also authorize agents of any hospital, treatment center or previous physicians to furnish HPCC copies of any records of my medical history, services or treatments, I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within HPCC.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to HPCC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding agreement to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to HPCC.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with HPCC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Signature _____ **Date/Time** _____ **AM or PM** (circle one)

Responsible Party Signature _____ **Relationship** _____ **Date/Time** _____ **AM or PM** (circle one)

PHYSICIAN: .....

ACCT NBR: ..... LOC: .....

FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

CONFIDENTIAL

1 - MEDICAL RECORDS 2 - BUSINESS OFFICE/MEDICAL RECORDS 3 - PATIENT

Revised 03/14

HYDE PARK CANCER CENTER

Courtesy Insurance Billing Service Authorization

With this service, we are able to bill your insurance directly and save you the paperwork. We need the following authorization from you in order for this to work correctly:

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, AND I HEREBY AGREE TO PAY AS SPECIFIED BELOW.

We will submit your claims for services provided by HPCC to your insurance company.

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION

1. **We expect full payment from your insurance company within forty-five (45) days of date of service. If your insurance company has not paid by then, you will be sent a bill and need to make the payment within thirty (30) days. Your account balance remains your responsibility.**

2. Under our Courtesy Billing Program, we have asked your insurance company to pay us directly, however, some insurance companies may pay the patient instead. If this occurs, you should sign the check over to HPCC, mail it with the insurance explanation of benefits and the stub from your monthly statement.

3. You must notify us IMMEDIATELY of any change in your insurance coverage or address/telephone number.

4. Account balances not paid after sixty (60) days may be subject to a 1.5% per month late payment charge. This charge will be billed to you not to your insurance company.

I have read the above Courtesy Insurance Billing Program, and understand all aspects of the program. I understand that I will be responsible for any amount not paid by my insurance within 45 days.

_____ _____

Patient Signature **Date**

_____ _____

Guarantor's/Spouse Signature **Date**