FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
DOB: _____
MRN: _____

FOR OFFICE USE ONLY

Dear Patient,

Welcome to Florida Cancer Specialists & Research Institute (FCS)! Throughout your time with us, you will meet a dedicated team of nurses and other professionals. Each is committed to addressing your concerns and providing the highest quality of care to support you on your journey.

Over the course of your care, you may be assigned to an advanced practice provider (APP) for routine hematology, oncology and symptom management appointments.

APPs are an integral part of our FCS care team. They include advanced practice registered nurses (APRNs) or physician assistants (PAs) who have earned advanced degrees and have specialized training in oncology. They are fully qualified to manage a wide variety of care needs, such as reviewing blood results and pathology and radiology scans. They can also prescribe medications and order infusions.

Individually and collectively, the members of your care team, including our APPs, are centered on you and committed to making sure you achieve the best possible outcome.

In addition to providing excellent care, our APPs play a key role in leading healthcare efforts and improving clinical outcomes. They work closely with your physician, who oversees all aspects of your care plan, to ensure it's personalized to your unique needs.

Feel free to ask questions and let us know how we can help you. Thank you for entrusting your care to us.

Your Florida Cancer Specialists & Research Institute Team

FLORIDA CANCER SPECIALISTS & Research Institute

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First Name:	Middle:	Last:	Suffix:

Preferred / Nick Name:	Date of Birth:
Primary Address:	SSN:
City, State, Zip:	Gender at birth: ☐ Male ☐ Female Gender Identity (Select one) ☐ Male ☐ Other _____ ☐ Female ☐ Prefer not to say
Secondary Address:	
City, State, Zip: From: _____ To: _____	Preferred Pharmacy: _____ Phone Number: _____ Pharmacy Address: _____
Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race (Select all that apply): ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other:_____	Phone Numbers Home: _____ Mobile: _____ Other: _____ Preferred Contact: ☐ Home ☐ Cell May we leave a voicemail? ☐ Yes ☐ No If yes: ☐ Home ☐ Cell ☐ Both May we text you? ☐ Yes ☐ No
Have you served or currently are serving in the US Military? ☐ Veteran ☐ Active Duty	Emergency Contact: _____ Phone Number: _____ Relationship: _____
Primary Care Physician: _____ Phone Number: _____ Do you see your PCP at least yearly? ☐Yes ☐No	Email: May we email you? ☐ Yes ☐ No
Referring Provider (if different from PCP) Name: _____ Phone Number: _____	Would you like access to the online patient portal? ☐ Yes ☐ No If yes, provide email address above.

FLORIDA CANCER SPECIALISTS & Research Institute

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INSURANCE INFORMATION

Patient Name: _____ DOB: _____

Primary Insurance Carrier: _____

Name of primary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____ Policy holder's SSN: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____ RX policy number/RX BIN number: _____

I certify that the information provided is accurate. I will notify Florida Cancer Specialists & Research Institute (FCS) of any changes as soon as they become available. I understand that it is my responsibility to update FCS of any changes to my insurance plan, or I may be held liable for the full balance of my treatment.

Patient Name (Print) _____ Date of Birth _____

Patient or Guarantor (Signature) _____ Date _____

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists & Research Institute or Rx To Go for any services furnished by _____. I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient Name (Print) _____ Date of birth _____

Patient or Guarantor (Signature) _____ Date _____

FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
DOB: _____
MRN: _____

FOR OFFICE USE ONLY

GENERAL & FINANCIAL CONSENT

Dear Valued Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS' patient general and financial policies:

- You consent to the rendering of medical care in compliance with healthcare surrogacy laws, which may include diagnostic procedures, next-generation sequencing testing and such medical treatment as your physician(s) or other FCS medical staff consider to be necessary. You may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. You consent to initiating and/or receiving technology-based communications with FCS and my providers, including consulting services from a specialist performed virtually. You understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. You have read and understand this General Consent for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.
- You agree to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
    - You understand that FCS patient financial policies are available online at FLCancer.com. You agree that these policies apply to you and may change from time to time without notice.
    - You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and you are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- You authorize FCS and its agents to review your insurance, financial, and demographic information for the purposes of identifying potential financial assistance programs for which you may qualify. This review may include the use of 3rd party services to help determine eligibility for financial support.
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.

FLORIDA CANCER SPECIALISTS & Research Institute

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FOR OFFICE USE ONLY

- FCS owns and operates Rx To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use Rx To Go and may have your prescriptions filled wherever you choose. However, if you select Rx To Go to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by Rx To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS' own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS' care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

☐ I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.

A copy is available to the patient upon request.

_____ _____
Patient Name (Print) Date of birth

_____ _____
Patient or Guarantor (Signature) Date

For office use:

_____
Name (Print)

_____
FCS Employee (Signature)

FLORIDA CANCER SPECIALISTS & Research Institute

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FOR OFFICE USE ONLY

GENERAL CONSENT FORM

SMS Communication Consent

☐ I consent to receive text messages from Florida Cancer Specialists & Research Institute (FCS), Rx To Go, LLC, and any authorized texting service vendor for appointment reminders, billing notices, and other health-related updates. I understand message/data rates may apply and I may opt out at any time by replying "STOP."

☐ I do not consent to receive text messages.

Photo Authorization for Medical Record

☐ I consent to FCS photographing me (digital/photo/video) for inclusion in my electronic medical record (EMR) for identification and documentation purposes.

☐ I do not consent to be photographed for medical record purposes.

Consent Disclosure of Medical Information

☐ I authorize FCS to discuss my medical information with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and to no other family members or friends.

Medical Scribe Consent

☐ I give permission for FCS to use a professional medical scribe, who may be virtual, to assist my physician during documentation. I understand this service is provided at no cost and all shared information will remain confidential.

☐ I do not give permission for FCS to use a professional medical scribe.

Florida Cancer Specialists & Research Institute (FCS) is using an AI Scribe tool to improve patient care by helping providers focus more on you during visits. The AI Scribe listens to your conversation with your provider and creates a clinical note, which your provider reviews and approves before it's added to your medical record. Your privacy is protected through strict adherence to federal and state privacy laws and regulations, with added security measures like encryption and multifactor authentication. Participation is voluntary, and you may withdraw consent at any time.

Patient Medication Reconciliation

I consent to FCS and its healthcare providers to collect, document, and reconcile my current medications as part of my medical care. This includes but is not limited to, prescription drugs, over-the-counter medications, vitamins, supplements, and herbal remedies and recording the name, dosage, frequency, and route of administration for each medication. This process is essential for ensuring safe and effective treatment and is required under the Merit-based Incentive Payment System (MIPS) guidelines. I may revoke this consent in writing at any time, except to the extent that action has already been taken based on this consent.

☐ Yes

☐ No

Patient (Print Name) _____ Date of birth _____

Patient (Signature) _____ Date _____

FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
DOB: _____
MRN: _____

FOR OFFICE USE ONLY

EXPRESS CONSENT TO NEXT GENERATION SEQUENCING

General Description & Purpose of Genetic Testing
I understand that my health care provider may recommend genetic testing as part of my care plan. Genetic testing results may reveal information that i) shows whether you have a genetic change (or variant) that may increase or decrease your chance of developing certain health conditions in the future ii) may have implications for your biological family members, including whether they may have, be at risk, or be a carrier of a genetic condition iii) may affect your medical care, including helping to confirm a diagnosis or guide decisions about treatment, screening or prevention.

By signing this form, I agree to genetic testing and to the collection, use, storage and sharing of my genetic information as needed to perform the test and support my care. This may include by Florida Cancer Specialists & Research Institute ("FCS") and trusted third-parties who assist with imaging, laboratory tests and analysis, etc., and business associates, to help inform my diagnosis or treatment, as determined appropriate by my provider.

Benefits of Genetic testing
Genetic testing looks for changes in genes that may help support or clarify a diagnosis, aid in identifying or detection of cancer or inherited disorders, or help my provider choose the most appropriate treatment or care plan.

Limitations of Genetic testing
Genetic testing has limitations. For example, a test may not identify changes (a variant) even if one is present. Some results may not have a clear or certain meaning. While results are generally reliable, rare errors occur due to factors such as sample quality or incomplete information.
NOTE: I will inform my provider if I have had a blood transfusion or bone marrow transplant, as this may affect genetic testing results.

Manner of Collection
I understand that there are various methods of specimen collection for genetic testing, which may include obtaining DNA or RNA from peripheral blood, bone marrow aspirate or clots, fine needle aspirate, and formalin-fixed paraffin-embedded tissue.

Privacy and Sharing of Results
My test results will be kept confidential and shared only:

- With my ordering health care provider (or their designee)
- With me
- As otherwise authorized by me, or
- As required or permitted by law

We may share your information with trusted service providers (called "business associates") who support our operations. These trusted service providers are required to protect your information pursuant to HIPAA also. Federal law, including the Genetic Information Nondiscrimination Act (GINA), provides certain protections against the misuse of genetic information.

Use, Retention, Maintenance, and Disclosure of Samples
I understand my sample may be de-identified (meaning it cannot reasonably be linked back to me) for purposes such as improving testing processes, quality assurance and validation, and training and internal development. In some cases, we may use or share de-identified information for health care operations and research, analytics, or other lawful purposes, including collaborations with business associates. These activities may involve commercial uses. Unless otherwise required, my identifiable sample(s) will not be stored long-term and will typically be discarded within approximately 60 days after testing has been completed.

Acknowledgment and Consent
I understand the above information and have had the opportunity to ask questions. I know that genetic testing is voluntary, and I may choose not to proceed. By signing below, I agree to proceed with genetic testing as recommended by my provider.

_____	_____	_____
Signature of Patient or Patient's Authorized Representative	Relationship to Patient (if Authorized Representative)	Date
_____	_____	_____
Signature of Witness	Witness Relationship to Patient or Title	Date

Notice of Privacy Policies

Genetic Information
We may collect and use genetic information (such as results from genetic tests) as part of your medical record.
We use and disclose genetic information as permitted by HIPAA Privacy Rule, including for:

- Treatment (such as diagnosis and care decisions)
- Health care operations (such as quality improvement and care coordination)
- Certain research activities, when allowed by law

We may share this information with other third-parties (business associates) who help us operate our practice. These parties are also required to comply with HIPAA safeguard to protect your information.
In some cases, we may use or share de-identified information for research, analytics, or other lawful purposes, including collaborations with third parties. These activities may involve commercial uses. De-identified information does not identify you and cannot reasonably be linked back to you.
Participation in genetic testing is voluntary. Please speak with your provider if you have questions about whether genetic testing is right for you.

FLORIDA CANCER SPECIALISTS & Research Institute

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FOR OFFICE USE ONLY

ACP – Advance Care Planning Documents (If yes, please provide a copy)

Do you have an advance directive?	☐ Yes ☐ No	
Do you have a living will?	☐ Yes ☐ No	
Do you have a DNR?	☐ Yes ☐ No	
Do you have a healthcare proxy?	☐ Yes ☐ No	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Florida Cancer Specialists & Research Institute (FCS) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any FCS facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 2890 Center Pointe Drive, Fort Myers, FL 33916.

You may also obtain a copy of the Notice of Privacy Practices by visiting the FCS website at FLCancer.com, select the Patient Guide tab, select New Patient Forms and click on Notice of Privacy Policies.

☐ Accepted ☐ Declined

Patient Name (Print) _____ Date of Birth _____

Patient or Guarantor (Signature) _____ Date _____

Relationship to Patient: _____

REQUEST FOR RELEASE OF RECORDS

I authorize Florida Cancer Specialists & Research Institute (FCS) to request a copy of my complete medical record from the provider listed below:

Name of Provider/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

I understand that by signing this authorization, I permit FCS to receive my medical, psychiatric, HIV, drug/alcohol, and other sensitive health records, unless otherwise restricted by law. I also understand this authorization is valid until revoked in writing.

Patient Name (Print): _____ Date of Birth: _____

Patient or Guarantor Signature: _____ Relationship: _____ Date: _____

FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
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FOR OFFICE USE ONLY

HEALTH HISTORY

ALLERGIES

Drug name:	Reaction you have:
Other Allergens:	
☐ CT Dye	
☐ Iodine	
☐ Latex	
☐ Other _____	

MEDICATIONS

Please list all medications you are currently taking, include dosage and frequency. If you have a printed list, you may provide a copy to the office instead.

Name of Medication:	Strength:	Frequency Taken:

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PAST MEDICAL HISTORY

Have you ever been told by a doctor/health care professional that you had cancer? ☐ Yes ☐ No

If yes, type of cancer: _____ date diagnosed: _____

Treating physician and type of treatment: _____

Do you have religious restrictions that prevent you from accepting blood transfusions? ☐ Yes ☐ No

Blood Transfusions: _____

☐ None	☐ Gallstones	☐ Osteoarthritis
☐ Anemia	☐ GERD/heartburn	☐ Osteoporosis
☐ Anxiety disorder	☐ Glaucoma/cataracts	☐ Pancreatitis
☐ Asthma	☐ Hearing loss	☐ Paralysis
☐ Atrial fibrillation	☐ Heart murmur	☐ Parkinson's disease
☐ Bleeding disorder	☐ Heart attack-MI	☐ Peripheral vascular disease
☐ Blood clots	☐ Heart disease	☐ Pneumonia/bronchitis
☐ Blood disorder	☐ Heartburn/reflux	☐ Problems with anesthesia
☐ Cancer	☐ Hepatitis A/B/C/HIV	☐ Raynaud's syndrome
☐ Chronic back pain	☐ Hiatal hernia	☐ Rheumatic fever
☐ Chronic lung (COPD)	☐ High blood pressure	☐ Rheumatoid arthritis
☐ Cirrhosis of liver	☐ High cholesterol	☐ Seizures
☐ Colon polyps	☐ Irregular heartbeat	☐ Shingles
☐ Congestive heart failure	☐ Irritable bowel syndrome	☐ Sleep apnea
☐ Crohn's disease	☐ Kidney disease/failure	☐ Stomach ulcers
☐ Diabetes	☐ Kidney stone	☐ Stroke
☐ Diverticulitis	☐ Leukemia	☐ TB (Tuberculosis)
☐ Drug use	☐ Lupus-autoimmune	☐ Thyroid disease
☐ Enlarged prostate	☐ Lymphoma	☐ Ulcerative colitis
☐ Fracture	☐ Major depression	☐ Other: _____
☐ Freq. urinary tract infections	☐ Migraines	☐ Other: _____
☐ Frequent infections	☐ Neuropathy	☐ Other: _____

PAST SURGERIES	When	Where

RECENT HOSPITAL ADMISSIONS	When	Where

WOMEN'S HEALTH HISTORY (if not applicable, skip and continue to the next page)	
Age menstruation began:	Age of menopause (if applicable):
Age at first pregnancy (if applicable):	Were you ever on hormone replacement? ☐ Yes ☐ No
Last menstrual period:	If yes, when did you start/stop?:

FLORIDA CANCER SPECIALISTS & Research Institute

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SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, what? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Other_____ # per day: _____ Have you ever smoked? ☐ Yes ☐ No Started at age: _____Quit at age: _____ Interested in quitting? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No If yes, what? ☐ Wine ☐ Liquor ☐ Cocktails ☐ Beer ☐ Other _____ How often? ☐ Daily ☐ Weekend ☐ Socially

Drinks per day ☐ 1-2 ☐ 3-5 ☐ >5

Started at age: _____ Quit at age: _____

Children: ☐ Yes ☐ No If yes, how many? _____

Relationship Status:		Occupation Status:	
☐ Single	☐ Divorced	☐ Employed full-time	☐ Student
☐ Married	☐ Widowed	☐ Employed part-time	☐ Retired
☐ Partnered		☐ Unemployed	☐ Homemaker
			☐ Unable to work

Occupational exposure to hazardous material? ☐ Yes ☐ No If yes, ☐ Radiation ☐ Chemicals ☐ Other Particles

_____

HEALTH MAINTENANCE HISTORY

Last GYN exam: _____ Last dental exam: _____ Last mammogram: _____	☐ EGD date: _____ ☐ EKG/Echo date: _____ ☐ Last CT chest lung cancer screening (if smoker):	Last colonoscopy or CRC screening test: _____

Do you receive prophylactic vaccines? ☐ Yes ☐ No Are you up to date with recommended vaccines? ☐ Yes ☐ No	List vaccine and dates received:

FAMILY HISTORY

Any bleeding or clotting disorders in family member? ☐ Yes ☐ No

If yes, which relative(s) and what type? _____

Have any family members had genetic testing? ☐ Yes ☐ No

If yes, which relative(s) and what were the results? _____

Relative	Disease	Cancer type if applicable	Age at Diagnosis	Cause of Death
Father				
Mother				
Siblings				
Child(ren)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Other Relatives				

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CURRENT SYMPTONS

General
- ☐ Change in appetite
- ☐ Change in weight
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Frequent colds

Eyes
- ☐ Glasses/contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision

Ears, nose, mouth, throat
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Postnasal drip
- ☐ Dental problems
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums

Heart
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet or ankles

Lungs
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ Difficulty breathing when lying flat

Musculoskeletal
- ☐ Joint pain/arthritis
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle aches

Genitourinary
- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Urine leakage
- ☐ Pain/burning with urination
- ☐ Pelvic pain
- ☐ Blood in the urine

Men only
- ☐ Prostate infections
- ☐ Impotence

Women only
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful intercourse
- ☐ Cramping

Digestive
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Belching or excess gas
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids

Endocrine
- ☐ Hot flashes
- ☐ Heat intolerance
- ☐ Cold intolerance

Immunologic
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever

Skin
- ☐ Rash, hives or itching
- ☐ Change in color
- ☐ Change in mole or wart
- ☐ A sore that won't heal

Nervous system
- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Convulsions, seizures or tremors
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs

Blood disorders
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood transfusion(s)

Psychiatric
- ☐ Anxiety disorder
- ☐ Major depression
- ☐ Trouble sleeping/insomnia
- ☐ Work/family stress

Other
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____