The Toledo Clinic | Cancer Centers

Dear Patient,

Welcome to The Toledo Clinic Cancer Centers. Whether it be a cancer diagnosis or a blood disorder, it is our goal to provide you and the loved ones that support you during this journey with access to our high quality services and compassionate staff.

Additionally, we are committed to maximizing our services within Northwest Ohio and Southeast Michigan so that you can be properly treated without traveling far from home. As our Senior Partner of medical oncology says, "You can get the best care possible and sleep in your own bed".

The Toledo Clinic Cancer Centers has access to all the services you may need. Your physician and their care teams will assist you and be there with you the entire way. In addition to being the largest hematology/oncology group in the community, our physician team consists of the most experienced and educated hematologists and oncologists in the region. You can expect to receive the best care with the best possible outcome while being provided with a caring support team to assist you throughout your journey.

The Toledo Clinic Cancer Centers has been instrumental in forming a collaboration with several excellent healthcare organizations to provide the comprehensive services needed for your care. This network consists of The Toledo Clinic Cancer Centers, along with access to care from the Dana Cancer Center at the University of Toledo, the Maurer Family Cancer Care Center at Wood County Hospital, Fulton County Health Center, Henry County Hospital, and the Karmanos Cancer Institute. Not only does this improve access, but it also provides timely care when it's needed most.

At your first appointment, you will receive a new patient resource guide which will include everything you need to know as well as contact information for any situation that may arise. Please don't hesitate to reach out to any member of your care team at any time.

We are here for you every step of the way!

Your Care Team at The Toledo Clinic Cancer Centers

The Toledo Clinic | Cancer Centers

Patient Centered Care Services

Physical Support

- Nutrition Consultation
- Fertility Preservation Consult & Treatment
- Integrative Oncology (acupuncture, massage, etc.)
- Prehab/rehabilitation & Physical Therapy Services
- Bone Health

Clinical Support

- Access to Advanced Clinic Trials
- Access to Advanced Treatment Options
- Outpatient Pharmacy for Oral Oncology Medications
- Medication Management Program
- Genetic Counseling
- Smoking Cessation

Financial Support

- Financial Needs Counseling & Navigation
- Access to The Cancer Care Alliance Foundation

Emotional Support

- Survivorship Planning
- Image Recovery (hair loss, wigs, skin care, etc.)
- Art Therapy

Other

- Patient Navigation
- Addressing Practical Needs
- Supportive Care Services

Bellevue
1400 W. Main St.
Bellevue, OH 44811
419.484.5400

Bowling Green
960 W. Wooster St
Suite 111
Bowling Green, OH 43402
419.353.5419

Maumee
1200 Medical Center Pkwy.
Maumee, OH 43537
419.794.7720

Monroe
800 Stewart Rd.
Suite B
Monroe, MI 48162
734.242.7902

Napoleon
1600 E. River Ave.
Suite 102
Napoleon, OH 43545
419.592.4015 ext. 3887

Oregon
4330 Navarre Ave.
Suite 103
Oregon, OH 43616
419.484.5400

Toledo
1325 Conference Dr.
Toledo, OH 43614
419.383.6644

Toledo
4126 N. Holland-Sylvania Rd.
Suite 105
Toledo, OH 43623
419.479.5605

Wauseon
725 S. Shoop Ave.
Wauseon, OH 43567
419.330.2708

Choose well, feel better.™

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First Visit Check List

The list provided below includes all necessary documents to be completed prior to your first visit and presented upon arrival. Please complete and sign where applicable before your scheduled appointment time.

- [ ] Patient Account Information
- [ ] Financial Policy/Privacy Policy
- [ ] New Patient Health History
- [ ] Consent to Release Protected Health Information
- [ ] Current Insurance Card(s) to include RX Card – Co-pays are due at the time of service
- [ ] Drivers License or Photo ID
- [ ] Current Medication List or Medication Bottles
- [ ] CD and/or report(s) of past radiology scans/test (if applicable)

Thank you for choosing The Toledo Clinic Cancer Centers as your healthcare provider. Our physicians, nurses and staff are dedicated to providing you with the highest quality care.

Date: ____/____/_____

Account Number: _____

Doctor: _____

Primary Care Physician & City: _____

The Toledo Clinic

Patient/Account Information

Use Black Ink Only

A. Patient Information

NAME: LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

MAIDEN/PREVIOUS NAME	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSE NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ Cellular Phone
- ☐ Home Phone
- ☐ E-Mail
- ☐ Text

RACE
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown
- ☐ Declined

ETHNICITY
- ☐ Hispanic or Latino
- ☐ No Hispanic or Latino
- ☐ Unknown
- ☐ Declined

LANGUAGE
- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Japanese
- ☐ Spanish
- ☐ Vietnamese
- ☐ Unknown
- ☐ Declined

B. Person Responsible For Payment - If Patient Is A Child, The Person Who Has Custody

NAME: LAST	FIRST	INITIAL	DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS

C. Insurance Information

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	RELATIONSHIP TO PATIENT

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	RELATIONSHIP TO PATIENT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT: _____

SIGNATURE

The Toledo Clinic

HIPPA Signature Form

ACKNOWLEGEMENT OF RECEIPT OF THE TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received The Toledo Clinic's Notice of Provicy Practices effective April 14, 2003, rev 03.31.2013.

STAFF USE ONLY

Patient Chart Number: _____

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date of Birth

_____

Signature of Parent/Guardian or Minor

_____

Date

STAFF USE ONLY

Good Faith Effort to Obtain Acknowledgement

The above name patient refused to sign the acknowledgement after being requested to do so.

_____

Staff Member Signature

Date: _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

Method of allowed release: ☐ Verbal ☐ Written

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

The Toledo Clinic | Cancer Centers

Patient History

Patient Name (First and Last): _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Referring Physician: _____

☐ Male ☐ Female Primary Care Physician: _____

Other Specialists: _____

Reason for Visit: _____

Personal Medical History: Check all that apply and include year of diagnosis

	Treating Doctor	Date of Diagnosis
☐ Alchohol dependence		
☐ Anemia		
☐ Angina/chest pain		
☐ Anxiety		
☐ Asthma		
☐ Blood disorder, Type:		
☐ Cancer, Type:		
☐ Cardiac Stent		
☐ Cirrhosis, due to alcohol		
☐ Colostomy/ileostomy		
☐ Coronary artery disease		
☐ Congestive heart disease/CHF		
☐ Chronic obstructive pulmonary disease/COPD		
☐ Depression		
☐ Diabetes, Type:		
☐ Dialysis		
☐ Drug dependence, Drug Name:		
☐ Emphysema		
☐ GERD		
☐ Heart arrhythmia		
☐ Heart attack/MI		

	Treating Doctor	Date of Diagnosis
☐ Heart valve disease		
☐ Hepatitis, Type:		
☐ High blood pressure		
☐ High cholesterol		
☐ HIV/AIDS		
☐ Inflammatory bowl disease		
☐ Kidney disease/renal failure Stage:		
☐ Neuropathy		
☐ Organ transplant, Type:		
☐ Pacemaker		
☐ Parkinson's disease		
☐ Paralysis		
☐ Pneumonia		
☐ Rheumatoid arthritis		
☐ Schizophernia		
☐ Seizure disorder		
☐ Stroke		
☐ Thyroid disease		
☐ Tuberculosis		
☐ Ulcer, Type:		
☐ Vertebral fractures		
☐ Other:		

List All Hospitalizations/Surgeries

Date	Reason for Hospitalization/Surgery Type	Location	Doctor

Previous Treatment for Cancer (if applicable)

Radiation Therapy: _____ Location: _____ Date: _____

Chemotherapy/Immunotherapy: _____ Location: _____ Date: _____

Hormone Therapy: _____ Location: _____ Date: _____

Patient History

Patient Name (First and Last): _____ Date of Birth: ____/____/_____

Immunizations: Check previous immunizations received and include date of last vaccine in known

	Date received		Date received
☐ Flu		☐ Hepatitis B	
☐ Shingles		☐ Pneumonia	
☐ COVID			

Medications: List current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins

Medication	Dose	Frequency	Start Date	Reason

Pharmacy Name and Location: _____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medications that you are allergic to and the type of reaction: _____

_____

_____

Are you allergic to:

Contrast/IV dye for scans: ☐ Yes ☐ No

Latex: ☐ Yes ☐ No

Tape: ☐ Yes ☐ No

Vaccines: ☐ Yes ☐ No If yes, list the type of vaccine: _____

Other allergies: _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No Reason: _____

If yes, did you have a reaction? ☐ Yes ☐ No

Date of last blood transfusion: _____

Patient History

Patient Name (First and Last): _____ Date of Birth: ____/____/_____

Screenings

	Date received		Date received
Last mammogram (female)		Last bone density scan	
Last PAP smear (female)		PSA/Prostate Exam	
Last colonoscopy/Cologuard or sigmoidoscopy		Low Dose CT Lung Scan	

Social History

Living arrangement: ☐ Single ☐ Married ☐ Partnered ☐ With family ☐ Separated ☐ Divorced ☐ Widowed ☐ Care facility

Number of pregnancies: _____ Number of children: _____

Occupation (previously if retired): _____

Have you served in the military? ☐ Yes ☐ No If yes, dates of service: _____

Do you currently use tobacco products?

Yes Number per day: Cigarettes: _____ Cigars: _____ Pipe: _____ Chewing tobacco: _____

For how many years have you used the above tobacco product?

No Have you ever used tobacco in the past? ☐ Yes ☐ No

When did you quit? _____ For how many years did you use tobacco products? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____

Do you have a history of alcoholism? ☐ Yes ☐ No

Have you used recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____

What do you do for exercise? _____ How many times per week? _____

Do you have an Advance Directive, Living Will, or Power of Attorney? ☐ Yes ☐ No

If yes, please bring to your next appointment.

Family History of Cancer

	Reason for Hospitalization/Surgery Type	Age at Diagnosis	Alive or Deceased
Father			
Mother			
Brother			
Sister			
Son			
Daughter			
Grandfather			
Grandmother			
Uncle			
Aunt			

Patient History

Patient Name (First and Last): _____ Date of Birth: ____/____/_____

Symptoms: Check all that apply or None

Do you have pain? ☐ Yes ☐ No If yes, where? _____ Intensity (0-10): _____ Frequency: _____

Do you have daily chronic pain? ☐ Yes ☐ No

If yes, where? _____ Intensity (0-10): _____ Frequency: _____

Constitutional:
- ☐ Appetite
  - ☐ Good
  - ☐ Fair
  - ☐ Poor
- ☐ Weight loss
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Altered taste
- ☐ Chills
- ☐ Night sweats
- ☐ Hot flashes
- ☐ None

Immunologic/Infections:
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever
- ☐ None

Hematologic/Lymphatic:
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Eyes:
- ☐ Glasses/contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ None

Ears, nose, mouth, throat:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sinus tenderness
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ None

Cardiovascular/Heart:
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet, ankles or hands
- ☐ None

Respiratory/Lungs
- ☐ Cough
- ☐ Sputum or phlegm production
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Black stools
- ☐ Change in bowl habits
- ☐ Hemorrhoids
- ☐ None

Genitourinary:
- ☐ Pain/burning with urination
- ☐ Excessive nighttime urination
- ☐ Slow starting or stopping
- ☐ Urgency
- ☐ Unable to hold urine
- ☐ Blood in the urine
- ☐ None

Gynecologic:
- ☐ Vaginal dryness
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Pelvic pain

GYN History:
- ☐ First menstrual period, age: _____
- ☐ Last menstrual period, age: _____
- ☐ Menopause, age: _____
- ☐ Number of pregnancies
- ☐ Number of live births
- ☐ Estrogen use: ☐ Yes ☐ No
  Number of years: _____
- ☐ Contraception, type used:

  _____

Musculoskeletal:
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Back pain
- ☐ Limited range of motion
- ☐ None

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ A sore that won't heal
- ☐ Dry skin
- ☐ None

Neurological:
- ☐ Headaches
- ☐ Seizures
- ☐ Poor coordination
- ☐ Weakness or arms or legs
- ☐ Paralysis
- ☐ Tremor
- ☐ Numbness in arms or legs
- ☐ Dizziness
- ☐ None

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping/insomnia
- ☐ Memory loss
- ☐ Confusion
- ☐ None

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Increased thirst
- ☐ None

Breasts:
- ☐ Breast mass
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Breast skin changes
- ☐ None

The Toledo Clinic

Financial Policy

We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Patients who do not have insurance are expected to pay for professional services at the time of service.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring his/her insurance card to each visit. If claims are rejected by insurance company due to untimely filing limits, and the delay is a result of the patient not providing insurance information timely, the patient will be responsible for all charges.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. The telephone number is printed on the insurance card.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash, or check at the time of service has been verified. Statements indicating any patient responsible balance will be mailed monthly. Payment in full is due within 30 days.
- Patient balances over 30 days will be subject to a late payment charge equal to 1.25% (15% annual percentage rate) of the balance as of the end of each month.
- Patients will be asked to pay all patient responsible balances in full when they are seen in the office at their next visit.
- Patients with outstanding balances may not be seen by the physician absent medical necessity and are subject to discharge from the practice.
- In the unanticipated event you are unable to pay your bill when due, please contact us as informal arrangements may be worked out.
- Any prepayments resulting in a credit balance to an account will first be applied to any outstanding debt prior to being refunded.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Business Services department at 419-479-5398. We are happy to help you.

I hereby authorize The Toledo Clinic to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, The Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

AUTHORIZED SIGNATURE

I understand and have read this form or had it read to me.

Signature of Patient/Authorized Representative	Relationship (if other than patient)
Patient Name	Date
Chart #	