David Brown, M.D.
Apoorva Chawla, M.D.
Shaili Desai, M.D.
Mersiha Hadziahmetovic, M.D.
Tim Kasunic, M.D.
Siddharth Kunte, M.D.
Rex Mowat, M.D.
Dhaval Parikh, M.D.
Richard C. Phinney, M.D.
M. Hammad Rashid, M.D.
Charu Trivedi, M.D.
Ahmad Zarzour, M.D.

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

1200 Medical Center Pkwy
Suite 1100
Maumee, OH 43537
Ph: 419.794.7720

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

800 Steward Rd
Suite B
Monroe, MI 48162
Ph: 734.242.7902

Dear Patient:

Welcome to The Toledo Clinic Hematology / Oncology Center. We are pleased you have chosen us as your care provider.

We have included in this packet, a patient registration form, and a medical history form. Please complete these before your appointment. ***Please bring the completed forms along with your current health insurance cards, photo ID, and all medication bottles.***

If your health plan requires a referral, please make sure it is in place prior to your visit date. Our agreement with your health plan will not allow us to see you unless the referral process is completed first.

If you are unable to keep your appointment at the scheduled time, we ask that you call at least 24 hours prior to your appointment time. We will make every effort to accommodate your requests.

We look forward to meeting you and caring for your medical needs.

Welcome to Toledo Clinic Cancer Centers, providing care you can believe in. We are partnering with your Primary Care Physician as they build your Medical Home. We are sharing their commitment to effectively and efficiently co-manage your care over-time. As your Specialist, we will be sharing limited or long-term management (depending on the nature and impact) of your condition and provide advice, guidance and periodic follow-up until the crisis or treatment has been stabilized or completed.

You may notice that:

- We will be communicating with your Primary Care Physician (PCP) and will be providing timely written reports on our consultations with you to them.
- We will be notifying your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- We will be providing future scheduled appointments and treatment plans.
- We will be notifying your PCP of referrals needed for other Specialties.

We trust you, our patient, to:

- Keep your appointments as scheduled, or call and let us know when you cannot
- Learn about your insurance, so you know what it covers
- Learn about wellness and how to prevent disease
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- See your PCP on an annual basis for all preventive services

We will continue to:

- Remind you when tests are due so that you can receive the best quality care
- Ask you to have blood tests done before your visit so that the doctor has the results at your visit

We are very pleased that you have selected us for your medical care and we appreciate the confidence and trust you have placed in us. We look forward to meeting with you personally and professionally as we provide you with the best, most personal patient centered care utilizing the latest in technology. As a team, our dedicated Physicians, Nurse Practitioners and support staff of clinical and business office personnel work together with you to provide the specialized healthcare you require. Included with this exceptional care and a part of your good healthcare practice is communication on our office and financial guidelines.

APPOINTMENTS

- In order to stay on time and provide the most comprehensive care to our patients, we require that all appointments be scheduled. Please call your main office number at **Toledo**: 419-479-5605, **Maumee:** 419-794-7720, **Bowling Green**: 419-353-5419, **Monroe, MI**: 734-242-7902 to schedule an appointment. Our appointment line is open from 8:00AM to 4:30PM Monday through Friday. (Office hours may vary by location.)
- Please call during our business hours to cancel or reschedule an appointment. Our answering service does not take messages about scheduling or cancelling appointments.
- Please be on time for your appointment. We request that you arrive 15 minutes early for your appointment to allow time for check-in. If you are late for a routine visit, we may need to reschedule your appointment so that our providers stay on time for all patients. Our providers strive to stay on time during the day but sometimes emergencies or complicated care issues can happen. We thank you for your patience during these times. If you wait longer than 30 minutes, we will offer to reschedule.
- We request that you give us 24 hours' notice if you are unable to keep an appointment so that we may open it to another patient. Three no-shows may result in dismissal from the practice.
- Please bring your insurance card and any required co-payment to each visit.
- It is important that you bring with you all prescriptions and over the counter medicines you take on a regular basis.

HEALTHCARE TEAM

When you are scheduled for a provider appointment, you may see your Physician or a Nurse Practitioner (NP) depending on the type of appointment that is scheduled. The physicians and NPs work closely together on your plan of care. There may be times when your appointment is switched from a physician to an NP due to certain circumstances, and although we will attempt to notify you ahead of time, there may be times when we are unable to do this. A physician is always available to see you in collaboration with the NP if the need arises.

ADDITIONAL NEEDS

- Hearing Impaired: DEAFinitely It Inc. 419-472-8377
- Please notify our office ahead of time if you need an interpreter for your appointment.

OFFICE PROTOCOLS

- In order to keep our offices clean, food and drinks are not allowed in our reception or exam rooms

- We need your full attention at your office visit and request that you do not use cell phones in our office. You will be asked to turn your cell phone off if this becomes a problem.

HOSPITALIZATIONS

- If you are hospitalized for any reason please contact our office. **419-479-5605.**
- Upon discharge for a hospital admission, an appointment with your provider will be required to continue treatment. Contact our office to make this appointment. **419-479-5605.**

MESSAGE AND CALL BACK POLICY

- We strive to provide the best in customer care and want any questions or concerns to be attended to in a timely manner. Our message and call back policy is designed to respond appropriately to phone messages, while allowing our providers to give the focused care patients need during office visits. Our providers work closely with our clinical support staff and business office. We encourage patients to contact our clinical phone triage line first for any health-related issues.
  Our message and call back guidelines are as follows:
- To leave a non-urgent message for a provider, call our main number at 419-479-5605 and press the appropriate option. A clinical phone triage person will send the provider a message if she/he is in the office that day or can send the message to another provider. Please note that it may be 24 to 48 hours before non-urgent messages are returned.
- If you are sick or your message requires more urgent follow-up, call our main number and press the appropriate option. Our clinical phone triage personnel will assess your symptoms using nationally-recognized patient care protocols and discuss recommendations with you. If medically appropriate, they will consult with one of our providers. You may be given an appointment to be seen the same day.
- If you are calling because your symptoms have not improved you will be asked to schedule a follow-up appointment with a healthcare provider so that we may examine you and reassess the situation.

AFTER HOURS CARE

- We have providers on call 24/7. Call **1-844-971-1918.** You will be transferred to the afterhours service and your message will be communicated to your physician or the physician on call.
- If you have a life-threatening situation and need immediate treatment, call 911 or go to the closest Emergency Room.
- If you have an urgent issue that needs to be addressed before the office is open, please go to a Little Clinic, located in Kroger stores. Please check Kroger listings for stores with Little Clinics. If a Little Clinic is not conveniently located near you, please choose an Urgent Care in your area that is covered by your insurance.

PRESCRIPTION REFILLS

- If your prescription was written with one or more additional refills available, please contact your pharmacy for refills. Refill requests are normally processed within two business days, so please contact your pharmacy several days before you are in need of the refill.
- Refills for controlled substances will **not** be processed over a weekend or holiday with on-call providers. Plan ahead and call the office. Narcotic refill requests will be processed within 2 business days. If you experience unrelieved pain, call to request an appointment.

REFERRALS

Our schedulers are available to help you with referrals made by our providers for specialized services. Please note that the referral process could take 4- 5 business days. If your insurance requires a prior authorization, this will be initiated by the facility our practice is referring you to. If a pre-authorization is required from our office, we will process the pre-authorization. You will leave your appointment will contact information regarding any referrals made, when possible.

PATIENT PORTAL

We encourage all of our patients to sign up and use the patient portal as all labs, radiology, provider progress notes and pertinent documents can be made available through this site. This allows you to view this important information at your convenience. Please supply the office with your email address and you will be sent information on how to sign-up for the patient portal.

LAB AND X-RAY RESULTS

Specialized lab and radiology test results are not given over the phone. Appointments are scheduled for those results. If you did not get a test done as ordered; call to reschedule your results appointment. Copies of applicable results will be sent to your portal with the visit if requested. You will be notified of all critical test results the day of the test. Non-critical results will be communicated at the next appointment, however will be on the portal for you to see after they are reviewed by a provider.

MEDICAL RECORDS AND FORMS

You may leave forms at any of our offices for completion, and we will contact you when the form is ready to be picked up. (Generally, 7-10 business days.) Some forms may require a $20 charge due to complexity and staff time to complete. These forms include: FMLA forms and any requiring physician signatures.

Transfer or copying of records requires a signed release form from the patient or the parent / guardian of a minor. If records are being sent to another physician, we will copy and send them at no charge. Records copied for personal use will incur a copying charge.

CONFIDENTIALITY

Toledo Clinic Cancer Centers fully complies with HIPAA regulations and our privacy policy has been made available to all patients.

RESPONSIBLE PARTY

You will be asked to identify one person who is responsible for coordinating your care with us. This is the person we will contact regarding any clinical or financial communications, though other adults may bring family members to a visit or carry health insurance. Please note that a divorce decree or other financial arrangement between two parties does not determine who Toledo Clinic Cancer Centers bills for services. We will bill the appropriate insurance(s), but will look to the Responsible Party for any balances remaining.

INSURANCE

Toledo Clinic Cancer Centers accepts most commercial insurances. If you have any questions about which insurance plans, we accept please ask front desk office staff. Contact our Billing Department at 419-479-5605.

Please note the following insurance guidelines

- Please use the patient's legal name for all insurance and medical records and a PCP (primary care provider) if your insurance requires a PCP
- In order to bill your insurance company for services provided, it is critical that we have current insurance information in our records. **We will ask for your current insurance card at each visit to ensure that our information is current.**

- If you have a deductible or health savings account plan, there may be a patient balance after the insurance company has paid their portion of the bill. We will bill you for this balance due with payment to be made within 30 days.
- It is the Responsible Party's responsibility to be aware of the patient's insurance benefits. Not all services provided by our office are covered by all plans. The Responsible Party will be charged for any service not covered by the patient's insurance plan. Please feel welcome to ask us if you have any questions about your insurance plan---we will do our best to assist you in understanding your coverage.
- If you have two or more insurances, we will bill the primary insurance and the secondary insurance(s). We request that you provide all necessary insurance information to our office and promptly respond to all insurance company requests to assist us in this coordination of benefits process.
- Your insurance company may request additional information from you before they process claims. Please respond promptly to any requests from your insurance company. Failure to respond promptly to insurance company requests can result in unpaid or denied claims, in which case the patient becomes fully responsible for these charges.

CO-PAYMENTS

- Many insurance plans require that the patient share in the cost of the visit by paying a co-payment. Co-payments are due at the time of the visit, prior to services being rendered. We accept cash, check, VISA, MasterCard and Discover.

- Non-payment of co-payments can result in billing charges and collection activity

PATIENTS WITH NO INSURANCE / SELF-PAY

A deposit is required prior to the office visit. A deposit of $100 is required for a new patient visit and $50 for established patients with the balance due within 30 days. Patients without insurance are eligible to receive the Toledo Clinic's self-pay rate which is 15% off. We will then bill you for any remaining balance due for the visit with payment to be made within 30 days. Please inform our reception staff how you will be taking care of the cost of your visit when you check-in. We accept VISA, MasterCard, Discover.

PAST DUE BALANCES

- If you have a balance on your account, you will be expected to make a payment when you check in.
- Past due accounts greater than 60 days are subject to third party action and potential discharge from the practice.

- If you need special payment arrangements, please contact our business office to speak to one of our customer service representatives. We are able to provide short-term payment plans for special situations.

Please feel welcome to contact our Patient Business Office at 1-800-444-3561 ext. 5398, with any questions you may have about our financial policies, your account or financial assistance programs.

I acknowledge that I have read and understand my responsibilities as a patient of Toledo Clinic Cancer Centers.

Patient Name_____ DOB _____
Print

Patient Signature_____Date_____

DATE	ACCOUNT NUMBER

DOCTOR	PRIMARY CARE PHYSICIAN & CITY

PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC

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	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

ADDITIONAL CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ 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
- ☐ NOT 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	SPECIALIST CO-PAY AMT

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	SPECIALIST CO-PAY AMT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE _____ DATE _____

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

I acknowledge that I have received Toledo Clinic's Notice of Privacy 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 of Minor

_____
Date

Staff use only

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment 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

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.
Please fill this form out as completely as possible and bring this to your appointment.

Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB:**
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:	**Do you have children?** ☐ No ☐ Yes Ages: _____
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ COVID-19	

Cancer History		
☐ Bladder cancer	☐ Esophageal cancer	☐ Pancreatic cancer
☐ Bone cancer	☐ Leukemia	☐ Prostate cancer
☐ Brain cancer	☐ Lung cancer	☐ Skin cancer
☐ Breast cancer	☐ Lymphoma	☐ Small intestine cancer
☐ Cervical cancer	☐ Multiple myeloma	☐ Uterine cancer
☐ Colon cancer	☐ Ovarian cancer	☐ Other: _____

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

Medical History		
☐ Allergies	☐ COVID-19	☐ Osteoporosis
☐ Alzheimer's disease	☐ Depression	☐ Polycythemia Vera
☐ Anemia	☐ Diabetes mellitus	☐ Rheumatoid arthritis
☐ Arthritis	☐ Fibrocystic breast	☐ Seizures
☐ Asthma	☐ GERD (heartburn)	☐ Sickle Cell anemia
☐ Bleeding disorder	☐ Glaucoma	☐ Stroke
☐ Blood transfusion	☐ Heart murmur	☐ Substance abuse
☐ Breast problems	☐ HIV/AIDS	☐ Thyroid disease
☐ Cataracts	☐ Hypertension (high blood pressure)	☐ TIA (transient ischemic attack)
☐ Chronic bronchitis	☐ Kidney disease	☐ Tuberculosis
☐ Cirrhosis	☐ Lupus	☐ Ulcers
☐ Clotting disorder	☐ Meningitis	☐ Other (specify):
☐ Congestive heart failure	☐ Myocardial infarction (heart attack)	
☐ COPD (Lung Disease)	☐ Nerve / muscle disease	

Surgical History (check any surgeries you have had and the date of surgery if you know it):		
Year	Reason	Hospital
	☐ Appendectomy	
	☐ Arterial bypass	
	☐ Back surgery	
	☐ Biopsy	
	☐ Cholecystectomy	
	☐ Hysterectomy	
	☐ Splenectomy	
	☐ Other (list below)	
Other hospitalizations		
Year	Reason	Hospital

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

Have you ever had a blood transfusion?	☐ Yes	☐ No
If yes, where?	Date of most recent transfusion:	

Allergies to medications		**Seasonal and/or Environmental Allergies**	
Name of the Drug	Reaction You Had	Allergen	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (continued)		
Name of the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Do you have adequate food and eat a balanced diet? *			☐ Yes	☐ No
	Rank salt intake	☐ High	☐ Medium	☐ Low	
	Rank fat intake	☐ High	☐ Medium	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

Tobacco	Do you use tobacco? *				☐ Yes	☐ No
	☐ Cigarettes Packs/day	☐ Vape Pen #/day	☐ Chew – #/day	☐ Pipe – #/day	☐ Cigars – #/day	
	☐ # of years	☐ Or years quit	☐ Exposed to secondhand smoke *			
	Are you ready to quit smoking and/or using smokeless tobacco?				☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy, list contraceptive or barrier method used:					
	Any discomfort with intercourse				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal	Do you live alone? *				☐ Yes	☐ No
	If no, who do you live with?					
	Do you live in more than one household? (snowbird, multiple households) *				☐ Yes	☐ No
	Do you have family or friends who you interact with routinely? *				☐ Yes	☐ No
	Are you able to complete day-to-day activities such as bathing, preparing meals, shopping, and managing finances on your own or with the assistance of others? *				☐ Yes	☐ No
	Do you have any trouble affording doctor's visits, medications, and/or tests ordered by your provider? *				☐ Yes	☐ No
	Do you have reliable transportation to medical appointments? *				☐ Yes	☐ No
	Do you have any difficulty reading written materials? *				☐ Yes	☐ No
Safety	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss that impacts your daily living? *				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental and emotional abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

FAMILY HEALTH HISTORY							
☐ I was adopted and do not know my family history.							
	Mother	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**Other (List)**
Anesthesia problems							
Bleeding disorders							
Blood count disorder							
Breast cancer							
Cancer							
Clotting disorder							
Colon cancer							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Leukemia							
Lung Cancer							
Lymphoma							
Melanoma							
Multiple myeloma							
Ovarian cancer							
Sarcoma							
Stroke							
Other (Specify)							
Alive (Yes, No, or N/A)							

MENTAL HEALTH		
Is stress a major problem for you? *	☐ Yes	☐ No
Do you feel depressed? *	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide? *	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself? *	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS		
Please circle any symptom that you feel currently.		
Category	**Issues**	**No Problems**
General	Appetite change Fatigue Fever Sweats Weight loss Weight gain Weakness	☐
Skin	Itching Rash Mole changes	☐
Eyes	Vision changes * Cataracts Glaucoma	☐
Ears / Nose / Mouth	Dizziness Ringing in ears Hoarseness Sore throat Runny nose Nose bleeds Difficulty hearing *	☐
Lungs	Shortness of breath at rest Shortness of breath at exertion Chest pain Coughing blood Wheezing Dry cough Productive cough	☐
Heart	Chest pain Palpitations Fainting episodes Leg pains Sleeping with more than one pillow	☐
GI	Abdominal pain Nausea Vomiting Diarrhea Constipation Jaundice Black stools Blood in stool Difficulty swallowing Hemorrhoids (internal) Hemorrhoids (external)	☐
Genitourinary	Painful urination Increased frequency Urgency Blood in urine Kidney stones Urinating at night	☐
Musculoskeletal	Arthritis Stiffness Swelling Weakness Backache	☐
Nervous system	Headache Seizure Dizziness Tremors Memory loss Paralysis Numbness / tingling Anxiety Depression Personality change Suicidal thoughts *	☐
Male reproductive	Testicular pain Swelling Sexual dysfunction	☐
Female reproductive	Pelvic pain Loss of period Abnormal bleeding Sexual dysfunction	☐
Hematologic	Bruising Bleeding Recurrent infections	☐
Lymph nodes	Enlargement Tenderness	☐

The Toledo Clinic | Cancer Centers

MRN:
Date of Appointment:

HEALTH HISTORY QUESTIONNAIRE

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times?		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

_____ _____ / _____ / _____

Printed name of person who completed this form Date (MM / DD / YYYY)

The Toledo Clinic | Cancer Centers

Patient Name: _____ **DOB:** _____

Advance Directive Declaration

DO YOU HAVE AN ADVANCE DIRECTIVE?

□ **Yes**, I do have an Advance Directive.
Which Type?
□ Living Will
□ Durable Power of Attorney for Health Care

□ **No**, I do not have an Advance Directive
□ I decline information on Advance Directives
□ I would like an Advance Directive Packet

Need signed Physician Order on file:

□ Do Not Resuscitate – Comfort Care (DNR-CC)
□ Do Not Resuscitate – Comfort Care Arrest

Patient or designee Initial: _____
Date: _____ Time: _____

□ Patient/Family/State will bring a copy of Advance Directive
Who will be providing a copy of the Advance Directive?

_____ _____ _____
Name Relationship Phone Number

□ Patient/Family/State will *not* bring a copy of Advance Directive

I understand that if an Advance Directive exists, I am being strongly encouraged to provide Toledo Clinic Cancer Centers (TCCC) with the most current copy. If I do not bring an Advance Directive to TCCC, it is because I have chosen to keep this document private and confidential. However, I do realize that the attending provider cannot utilize the Advance Directive until it is a part of the medical record.

_____ _____
Patient or Designee Signature Date

_____ _____
Witness Signature Date

The Toledo Clinic

4235 Secor Road
Toledo, Ohio 43623

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

_____ _____

Signature of Patient/Authorized Representative Relationship (if other than patient)

Patient Name _____ Date _____

Chart # _____

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.

Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment, and Operations. Toledo Clinic, Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of your protected health information for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure of your protected health information for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure of your protected health information for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other purposes for which we can use your protected health information without written authorization from you. In addition to using your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose your protected health information without your written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs, or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose 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.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Institutions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

D. Other uses and disclosures of your protected health information will only be made with your prior written authorization. This includes, but is not limited to: (i) uses and disclosures of psychotherapy notes (if applicable); (ii) certain uses and disclosures for marketing purposes, including direct or indirect remuneration to Toledo Clinic; (iii) uses and disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures not described herein. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. Your Individual Rights. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and healthcare operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction. You also have the right to restrict certain disclosures to a health plan if and when you pay out of pocket and in full for the health care item or service.

B. The Right to Receive Confidential Communications of Protected Health

Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via e-mail) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession, including an electronic copy of your protected health information that we maintain electronically in a designated record. We may impose a reasonable cost-based fee for the labor involved and supplies used for creating the copy of your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information, other than for purposes of treatment, payment, and health care operations. Depending on whether your particular doctor has incorporated electronic health records into his or her medical practice, you may have the right to obtain an accounting of all disclosures of protected health information. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper copy of this Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

G. The Right to Opt-Out of Fundraising Communications. In the event we choose to contact you for purposes of fundraising, you will be given the opportunity to opt out of such fundraising communications.

H. The Right to Opt-Out of Health Information Data Exchanges.

The Toledo Clinic endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of care and healthcare experience. The HIE provides us with a way to securely and efficiently share clinical information electronically with other physicians and health care providers that participate in the HIE network. Making your healthcare information available to other providers can also help reduce your costs by eliminating unnecessary duplication of tests. Your electronic health information will be used by Heath Information Exchange participants in order to: Provide you with medical treatment and related services; Evaluate and improve the quality of medical care provided to all patients. Unless you opt-out of this data exchange, The Toledo Clinic will share your electronic health information with other health information exchange participants that are involved with your care. This information includes, but is not limited to information about your diagnosis, test results, and medications. Opting-out does not prevent your provider from direct sharing of your health information from a direct provider to provider exchange. It also does not prevent the notification of your primary care provider from information related to services you have received in other facilities. Please be aware that federal law protects your health information from being improperly disclosed and you are able to opt-out at any time.

III. Our Duties to Safeguard Your Protected Health Information.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information. In the event of any breach of privacy regarding your protected health information, the Toledo Clinic is required to notify you.

B. Privacy Notice. The Toledo Clinic is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Department of Health and Human Services if you believe your privacy rights have been violated. You may file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint. To report a complaint or concern

Via Phone: 844-481-4941

Online: Toledoclinic.Ethicspoint.com

D. Contact Person and Telephone Number. If you have questions and/or would like additional information, you may contact Toledo Clinic's Privacy Officer at 419-479-5996.

E. Effective Date. This Privacy Notice is Effective March 31, 2013. Revised March, 19, 2019.

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. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

If your diagnosis requires chemotherapy, here is an outline of the steps that must be taken before your chemotherapy treatment can begin:

1. Your physician will write an order for chemotherapy.
2. If your insurance requires a prior authorization for chemotherapy, **please be aware that it will take at least 48 to 72 hours to get the authorization in place**.
3. Once the approval is received from your insurance, the nurse will contact you and set up an appointment for chemotherapy teaching.
4. Chemotherapy teaching is done by the nurse or nurse practitioner.
5. You are now ready to schedule an appointment to start y our chemotherapy agents.

Please feel free to contact our office at 419-479-5605 if you have any questions, and thank you for choosing The Toledo Clinic Cancer Centers.

Toledo Clinic Cancer Center – Main Office
4126 N. Holland Sylvania Rd. | Suite 105 | Toledo, OH 43623
Ph: 419.479.5605 | Fax: 419.473.2049

Bowling Green, OH Ph: 419.353.5419 | Fax: 419.353.3660
Maumee, OH Ph: 419.794.7720 | Fax: 419.724.2417
Monroe, MI Ph: 734.242.7902 | Fax: 734.242.9199

The Toledo Clinic | Cancer Centers

What is "shared decision-making" and Why is it important to me?

In shared decision-making and informed consent, you get information about your plan of care, and you get to make the final decision about how you want your plan of care designed. But shared decision-making takes informed consent a step further by also giving the patient more responsibility for their care. Research tells us that when patients participate in the decision making and understand what they need to do, they are more likely to follow through. And follow through leads to better outcomes for your health.

Shared decision-making is a newer way of talking about your health and medical care – especially your treatment decisions – and more doctors are using it. It works like this: when you have been diagnosed with a medical condition, the doctor gives the patient information about the pros and cons of all your treatment options, including no treatment. This often means "homework" for the patient, such as reading, looking at DVDs, or sifting through other types of information. The patient tells the doctor about personal factors, such as, preferences, health problems, and home conditions that might make one treatment option better or worse than the others. Together, the patient and doctor decide which option is best for the patient. Or they may decide on something else, such as waiting for further developments.

This is quite different from just saying "yes" or "no" to the treatment the doctor offers you. It may mean that you must take in more information, ask more questions, share more about yourself, and take more time to sort through your options together.

This type of decision-making is especially helpful when there is no single "best" option. For many people, the extra effort is worth it – they feel more certain that they made the best choice for themselves. But for others, this responsibility may be too much or feel overwhelming. In those situations, it's okay to tell the doctor that you don't want to share in the decision-making regarding your plan of care and prefer for him to use his expertise – and his knowledge about you – to make decisions about your care.

But if you do want to be involved in the decision making regarding your plan of care, then you must let your doctor know. Tell your doctor and the health care team working with you that you want to be involved. Request written information on all your different options for treatment, including side effects, costs, and prognosis. Ask your doctor and health care team to explain all of these options to you. Be sure that you understand all the options for your situation, and ask questions if you do not understand.

Your healthcare team includes the staff in the doctor's office and in the hospital, as well as all health care professionals. They are here to answer questions, educate you and your family, and assist you when you do not understand any of the details in your plan of care. They are here to explain any changes in your medical condition as well as all the options to address those changes. Make a habit of writing your questions down. Keep in mind that your doctor may not have as much information about some aspects of your plan of care as others. And, realize you may need to get a second opinion for a more complete picture. Some doctors may even encourage a second opinion, especially when you have a rare or unusual cancer diagnosis.

Essentially, shared decision-making is designed to help providers and patients agree on a health care plan and work as a team for better outcomes. When patients participate in decision making and understand what they need to do, they are more likely to follow through. And following through on a care plan is what leads to the best success for achieving your goals for good health and wellbeing.