Low Country Cancer Care ASSOCIATES P.C.

O. George Negrea M.D.

Jennifer Yannucci M.D.

Savannah Office
225 Candler Drive
Suite 201
Savannah, GA 31405

Hinesville Office
790 Veterans Parkway
Suite 102
Hinesville, GA 31313

Bluffton Office
8 Okatie Center Blvd South
Legacy Medical Center
Bldg 8 Suite 201
Okatie, SC 29909

(P) 912-692-2000 (F) 912-692-2100

Welcome to Our Practice

Dear _____

We are dedicated to providing you with the best possible care and service. Please take a few minutes to fill out the following forms completely. Bring these forms with you for your appointment,

On _____ With _____

At our office in _____

Please arrive 15 minutes prior to your scheduled appointment with your insurance card(s) and any medications that you are currently taking. Also, please be prepared to pay any insurance co-pays at the time of service.

Thank you for choosing Low Country Cancer Care for your medical needs.

Please do not hesitate to call with any questions or concerns.

Sincerely,

The Low Country Cancer Care Staff

Low Country Cancer Care ASSOCIATES P.C.

Appointment Date: _____ LCCC Initials: _____
LCCC Office Location:_____
LCCC Physician: _____
Primary Care Physician: _____

PATIENT REGISTRATION

Patient Name (First, MI, Last):_____

Sex: □M □F Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-mail Address: _____ Preferred Contact Number:_____

Marital Status: □Single □Married □Divorced □Widowed □Life Partner

Race: □Hispanic/Latino □Asian □White □African American/Black □Other _____

Employer: _____ □Full-Time □ Part-Time □Retired □None

Responsible Party or Spouse's Name:_____

Phone Numbers: Home: _____ Cell: _____Work: _____

Employer: _____ □Full-Time □ Part-Time □Retired □None

Emergency Contact:_____ Relationship: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

PRECERTIFICATION AND REFERRALS:
If your insurance company requires precertification or office referrals, it is your responsibility to see that these are in place prior to all admissions or office visits. Any charges not covered as a result of non-certification will be your responsibility.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Low Country Cancer Care P.C. SUPPORTS THE USE OF MID-LEVEL PROVIDERS. YOU MAY PERIODICALY BE SEEN BY A PHYSICIAN ASSISTANT AND/OR NURSE PRACTITIONER.

Low Country Cancer Care ASSOCIATES P.C.

Please complete and update the following information as needed. Any charges incurred due to incorrect information will be the patient's responsibility.

INSURANCE INFORMATION

Primary Insurance Name:_____

Policy#: _____ **Group Number:** _____

Name of Subscriber: _____ **DOB:** _____ **SSN:** _____

Does your primary insurance require referral numbers? □Yes □No

Does your primary insurance require pre-certification? □Yes □No

Preferred Lab: _____ **Hospital:** _____ **Pharm:** _____

Secondary Insurance Name:_____

Policy#:_____ **Group Number:** _____

Name of Subscriber: _____ **DOB:** _____ **SSN:** _____

Does your secondary insurance require referral numbers? □Yes □No

Does your secondary insurance require pre-certification? □Yes □No

Preferred Lab: _____ **Hospital:** _____ **Pharm:** _____

IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE PLEASE COMPLETE THE BELOW QUESTIONS:

Are you still working? □Yes □No Retirement Date: _____

Do you have an employer group health coverage? □Yes □No

Is your spouse still working? □Yes □No Retirement Date: _____

Are you covered through your spouse's insurance? □Yes □No

Do you have prescription drug coverage? □Yes □No Program Name:_____

Are you a resident of a skilled nursing facility? □Yes □No

HIPPAA- NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The below signed patient acknowledges receipt of a copy of the Low Country Cancer Care Associates P.C. (LCCC) Notice of Privacy Practices (NOPP). The NOPP informs the patient of the possible uses and disclosures of protected health information (PHI) and the patient's privacy rights. The delivery of health care services will in no way be conditioned upon the patient's signed acknowledgement.

If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your PHI for treatment, payment and health care operations when necessary. The below signed patient understands that LCCC has the right to change its NOPP from time to time and that the patient may contact LCCC at any time to obtain a current copy of the NOPP.

If you have concerns, suggestions, and/or complaints you may contact the LCCC Privacy Office at: Lewis Cancer and Research Pavilion 225 Candler Drive Suite 201 Savannah, Georgia 31405 or by calling (912) 692-2000.

Patient Name (print): _____ DOB: _____

Signature of Patient/Legal Representative: _____

Relationship to Patient: _____ Date: _____

FOR OFFICE USE ONLY

Date: _____

I have attempted to obtain the patient's signature on this form, but was not able to because:

□ The patient refused to sign

□ Due to an emergency situation it was impossible to obtain an acknowledgement

□ I was not able to communicate with the patient

□ Other: (provide details below) _____

Employee Signature: _____ Date: _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Low Country Cancer Care to obtain or release any information necessary in order to provide me medical services and/or process insurance claims. I further authorize Low Country Cancer Care to obtain or release my medical information as needed for any healthcare related utilization review, quality assurance activities or other healthcare operations.

I further authorize Low Country Cancer Care to release my health records to the below individuals:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

INFORMATION TO BE RELEASED (Check All that Apply)

□ Entire Record □ Lab Results □ Radiological Results
□ Dictated Reports □ Nursing Notes □ Physician Orders □ Financials

FOR THE PURPOSE OF:

□ Anything on behalf of the patient
□ Creating/Changing/Cancelling appointments
□ View or correct demographic information to include signing in on my behalf
□ Receive documents containing my PHI on my behalf
□ Picking up prescriptions/ forms and or medication on my behalf
□ Speaking with LCCC staff regarding my PHI including but not limited to billing and insurance information on my behalf.
□ Other: _____

I understand that I have the right to revoke this Authorization in writing except to the extent that the practice has acted in reliance upon this Authorization. My written revocation must be submitted to the Privacy Official at:

Low Country Cancer Care Associates
225 Candler Drive
Suite 201
Savannah, GA 31405

Signed by: _____ Date: _____

Printed Name: _____ Relationship (if other than patient) _____

Low Country Cancer Care ASSOCIATES P.C.

GENERAL CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary and will be performed by a LCCC Healthcare Professional.

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempt to identify the most common material risks and the alternatives (if any) associated with the procedures. I understand that various Healthcare Professionals may have differing opinions as to what constitutes material risk and alternative procedures.

If I have any questions or concerns regarding these procedures, I will ask the LCCC healthcare professional to provide me with additional information. I also understand that they may ask me to sign additional Informed Consent documents.

The procedures may include the following risks:

(1) **Physical tests, assessments, and treatments** may include vital signs, internal body examinations, wound cleaning, wound dressings, range of motion checks, and other similar procedures. The material risk associated with these types of procedures include, but are not limited to, allergic reactions and infections. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

(2) **Drawing Blood, Bodily Fluids or Tissue Samples** that may be done for laboratory testing and analysis. The material risks associated with these types of procedures include, but are not limited to, infection and bleeding. Apart from long-term observation and/or refusal of treatment, no practical alternatives exit.

(3) **Needle Sticks for Tests or for Administration of Medications**, such as injections whether intramuscularly, intravenously, subcutaneously, or intradermally. The material risks associated with these types of procedures include, but are not limited to, never damage, infection, allergic reaction and infiltration (which is fluid leakage into surrounding tissue). Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exit.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any procedure.

The Healthcare Professionals participating in my care will rely on documented medical, as well as other information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the procedures; therefore I agree to provide accurate and complete information about my medical history and conditions.

By signing this form, I consent to Low Country Cancer Care Health Professionals to perform procedures as they may deem reasonable, necessary or desirable in the exercise of their professional judgement, **including those procedures that may be unforeseen or not known to be needed at this time consent is obtained**; and I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures, and practical alternatives to the procedures.

Date Signed: _____ **Printed Name of Patient:** _____

Signature of Patient/Authorized Representative: _____

Relationship to Patient (if other than patient giving consent): _____

If applicable:
Reason patient unable to sign: _____

Consent Translated for a Non-English Speaking Patient: **Yes or No**
Name of Translator: _____

Signature of LCCC HP: _____

Printed Name of LCCC HP: _____

FINANCIAL POLICY & PROCEDURES

To Our Patients:

As you are aware, the medical insurance industry is changing rapidly**. It is vital that you keep us updated on your insurance coverage**. We will need to know if your insurance company requires any precertification, preauthorization, referral numbers, or special designated hospitals for tests and hospitalization. We request that you bring your insurance cards and personal identification with you **each visit** so we can make copies as necessary for our records. **It is the patient's responsibility to verify that our providers and facilities are in-network with their insurance policy.**

Co-payments are due at the time of service if required by your insurance. Please be prepared to make payment at each visit prior to seeing your physician.

In addition to co-payments, you will be responsible for any insurance **deductible and co-insurance**. Any balance due after insurance payments will be reflected on your monthly statement. If you are unable to make full payment, please ensure that you have contacted the Business Office to arrange a payment plan. (A fee of $25 will be applied to any returned checks)

To Our Patients Requiring Treatment:
The diagnosis of cancer or other blood related disorders can cause a great deal of uncertainty for patients and their families. It is our hope to lessen some of the uncertainty by fully addressing upfront the treatment costs for the plan of care prescribed by your LCCC physician.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance or any other health plan to Low Country Cancer Care Associates, P.C. I request that payment of such benefits be made on my behalf directly to LCCC. I understand that I am financially responsible for all charges whether or not paid by said insurer(s). I agree to pay for all amounts that are no covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible. I hereby authorize LCCC to release any information necessary to determine eligibility and/or reimbursement for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient/Responsible Party Signature: _____ **Date:** _____

Relationship if other than patient: _____

ADVANCED DIRECTIVES

Patient Name: _____ **Date:** _____

Please read the following important information:

The physicians and staff of Low Country Cancer Care Associates P.C., believe that it is important for all of us to consider our wishes for extraordinary medical care in the event of an unexpected, life threatening medical problem. This decision is best considered when we are well.
Our state legislature(s) understands that it is important for us to make our own decisions about medical care even when we become unable to make or communicate decisions. The Georgia and South Carolina Legislatures have provided a way to indicate our wished call the **Advanced Directive for Health Care.** Additional information may be obtained on www.noah-health.org about Advanced Directives. In addition, your nurse or physician are available to discuss any information, questions, or concerns you may have about Advanced Directives.

As a new patient to LCCC, our staff will ask you whether you have signed an Advance Directive. Your response on this form will be recorded in your medical record. If you have already signed legal documents that explain your Advanced Directives, our staff will request a copy of the documents for your medical record. These documents will help your family and our staff to make sure that your wishes are carried out in the event of a sudden problem, which prevents you from expressing your wishes at that time.

Of course, your decision to sign an Advanced Directive will in no way change the care that anyone at Low Country Cancer Care provides to you and your family.

Please indicate your current choice regarding Advanced Directives:

_____ **I have signed** an Advanced Directive and will provide a copy to LCCC. I understand that the staff and physicians of LCCC will not be able to follow the terms of my Advanced Directive until I provide them with a copy of the legal document.
_____ I have **not** signed an Advanced Directive, but **would like** additional information.
_____ I have **not** signed an Advanced Directive and **do not** wish further information at this time.

Patient Signature: _____ **Date:** _____

Low Country Cancer Care ASSOCIATES P.C.

PATIENT HISTORY INFORMATION

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Current Problem:

Describe your chief complaint/ symptoms: _____

_____

_____

Who referred you to our office? _____

Who is your primary care doctor? _____

Past Medical History: Check only those problems which apply.

☐ Hypertension ☐ Diabetes ☐ High Cholesterol ☐ Stroke ☐ Heart Trouble

☐ Arthritis/Gout ☐ Convulsions ☐ Bleeding Tendency ☐ Acute Infections

☐ Hereditary Defects ☐ Cancer, Type _____ ☐ Other, _____

Previous Hospitalizations/ Surgeries/ Serious Injuries:	When?

Current Medications (please include dosages and frequency):

_____

_____

_____

_____

Social History:

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Use of Alcohol: □ Never □ Yes, but quit- Years since you quit _____

□ Yes, current daily drinker- Drinks per day _____

□ Yes, current someday drinker- Days per week _____ Drinks per day _____

Use of Tobacco: □ Never □ Yes, but quit- Years since you quit _____

□ Yes, current daily smoker- Packs per day _____How many years _____

□ Yes, current daily smoker- Packs per day _____How many years _____

Use of Illicit Drugs: □ Never □ Type/Frequency: _____

Excessive exposure at home or work to: □ Fumes □ Dust □ Solvents □ Air Borne Particles

Occupation: _____

Family History: Please list Age, Disease, and if Deceased, Cause of Death

Father: _____ _____ _____

Mother: _____ _____ _____

Siblings: _____ _____ _____

Spouse: _____ _____ _____

Children: _____ _____ _____

Other: _____ _____ _____

Other: _____ _____ _____

Allergies:

Known food/drug allergies: _____

_____

_____

_____

_____

Review of Systems: Please check all that apply

Constitutional Symptoms:		Respiratory (continued):	
	Good general health lately		Shortness of breath
	Recent Weight change		Asthma or wheezing
	Fever		Pneumonia
	Fatigue	Gastrointestinal:	
	Night Sweats		Loss of appetite
Eyes:			Change in bowel movement
	Eye disease or injury		Nausea or vomiting
	Wear glasses/contact lenses		Frequent diarrhea
	Blurred or double vision		Painful bowel movements
	Glaucoma		Constipation
	Cataracts		Rectal bleeding
Ear, Nose, Mouth and Throat:			Blood in stool
	Hearing loss or ringing		Abdominal pain or heartburn
	Earaches or drainage		Peptic ulcer (stomach or duodenal)
	Chronic sinus problem or rhinitis		Jaundice
	Frequent nose bleeds		Hepatitis
	Mouth Sores		Cirrhosis
	Bleeding gums	Genitourinary:	
	Periodontal disease		Frequent urination
	Swollen glands in neck		Burning or painful urination
	Trouble with teeth		Blood in urine
Cardiovascular:			Change in force of strain when urinating
	Chest pain		Incontinence or dibbling
	Irregular heart beat		Kidney stones
	Shortness of breath w/ walking or lying		Sexual difficulty
	Swelling of feet, ankles or hands		Male- testicle pain
	High blood pressure		Female- pain with periods
	Cramps in legs while walking		Female- irregular periods
Respiratory:			Female- vaginal discharge
	Chronic or frequent coughs		Female- # of pregnancies
	Spitting up blood		Female- # of miscarriages

Musculoskeletal:		Neurological:	
	Joint pain		Frequent or recurring headaches
	Joint stiffness or swelling		Light headed or dizzy
	Weakness of muscles or joints		Convulsions or seizures
	Muscle pain or cramps		Numbness or tingling sensations
	Back pain		Tremors
	Cold extremities		Paralysis
	Difficulty walking		Stroke
	Arthritis		Head injury
Integumentary (skin, breast)		Psychiatric:	
	Rash or itching		Memory loss or confusion
	Change in skin color		Nervousness/ Anxiety
	Change in hair or nails		Depression
	Moles/ skin cancer		Insomnia
	Skin disease	Endocrine:	
	Breast pain		Glandular or hormone problem
	Breast lump		Thyroid disease
	Breast discharge		Diabetes
Allergic/Immunologic: (check if history of skin or other adverse reaction to:			Excessive thirst or urination
	Penicillin or other antibiotics		Heat or cold intolerance
	Morphine, Demerol, or other narcotics		Skin becoming drier
	Novocain or other anesthetics	Hematological/ Lymphatic	
	Aspirin or other pain serums		Slow to heal after cuts
	Tetanus antitoxin or other serums		Bleeding or bruising tendency
	Iodine, methlolate or other antiseptic		Anemia
	Other drugs/medications:		Phlebitis
			Past transfusion
			Enlarged glands