PennState Health Medical Group

ANDREWS PATEL HEMATOLOGY/ONCOLOGY

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OFFICE LOCATIONS
3912 Trindle Road
Camp Hill, PA 17011
P: 717-761-8740
F: 717-761-8792
Colette Brown
Practice Site Manager II

4518 Union Deposit Road
Second Floor
Harrisburg, PA 17111
P: 717-526-1030
F: 717-526-1032

355 N. 21st Street
Suite 301
Camp Hill, PA 17011
P: 717-798-3720
F: 717-531-0103

Rita Overcash, MHA, BSN, RN
Assoc. Director Ambulatory Practices
Penn State Health Medical Group
Community Practice Division

Hours of Operation
8am-5pm Monday-Thursday
8am-4:30pm Friday
24/7 Hospital & On-Call
https://www.pennstatehealth.org/locations/penn-state-health-medical-group-andrews-patel-hematologyoncology

Dear _____,

Thank you for choosing **Penn State Health Medical Group Andrews Patel Hematology/Oncology**.

Your new patient appointment with _____ is on _____ at _____.

Your initial visit to our office may take 1 ½ - 2 hours

We would like to take this opportunity to welcome you to **Penn State Health Medical Group Andrews Patel Hematology/Oncology**. Our physicians and staff are dedicated to offering the highest quality patient care in a gentle, efficient and pleasant manner.

Office Hours: Monday through Friday 8:00am to 5:00pm

Office Location:

- ☐ 3912 Trindle Road, Camp Hill PA 17011
  Parking is located on either side of the building, patients requiring handicap entrance should park on the left side of the building. Entrance is located on the left side of the building, at the top of the ramp..
- ☐ 4518 Union Deposit Road, Harrisburg PA 17111
  Entrance and parking is located at the back of the building.
- ☐ 355 N. 21st Street, Suite 301, Camp Hill PA 17011
  Entrance is at the front of the building. Take the elevator to the 3rd floor.

This packet includes:

- New Patient Registration Form
- Pain management agreement
- Financial Policy
- Patient Bill of Rights
- Information about advanced directives

Please complete and return the New Patient Registration form prior to your appointment. Please mail these items back to us in the enclosed self-addressed stamped envelope.

For your First Visit, please bring:

- Driver's License
- ALL insurance and prescription cards

We are looking forward to meeting you and building a relationship that will ensure that you receive the highest quality of care and service. Because we treat a variety of diseases and patients who are more susceptible to infections, we ask that infants, children under age 12, visitors with cold or flu symptoms, and animals other than certified service animals refrain from visiting our office.

Sincerely,

Colette Brown, Practice Site Manager Camp Hill Location
Heather Cassatt, Practice Sit Manager Harrisburg Location

PennState Health Medical Group

ANDREWS PATEL HEMATOLOGY/ONCOLOGY

New Patient Registration Form

(Please Print) Appointment Date:_____

PATIENT INFORMATION			
Dr. __ Mr. __ Mrs. __ Ms. __	First Name:	Middle:	Last:
Address:		Zip:	City & State:
Please indicate which number is primary by checking box: ☐ Home: ( ) ☐ Cell: ( ) ☐ Work: ( )		Social Security Number: DOB:	
Email Address:			Sex: ☐ Male ☐ Female

Marital Status:	Race:		Preferred Language:	Ethnicity:
☐ D	☐ American Indian	☐ White	☐ English	☐ Latino
☐ M	☐ Asian	☐ Other	☐ Spanish	
☐ S	☐ African American		☐ Other	☐ Non Latino
☐ W	☐ Pacific Islander		☐ Sign	

Spouse Name:	Spouse DOB and SS# (if insurance policy holder):
Are you a veteran: ☐ Yes ☐ No	Do you have any children?: ☐ Yes ☐ No # of sons: _____ # of daughters: _____
Referring Doctor:	Family Doctor:
Preferred Pharmacy:	Pharmacy Phone #:

HIPAA (include names of ALL persons we can release information to)			
Name	Relationship	Phone	Special Disclosures **
			Yes: ☐ No: ☐
			Yes: ☐ No: ☐
			Yes: ☐ No: ☐

** special disclosures include genetic testing, psychiatric, and drug and alcohol related information

FAMILY HISTORY

Family History of Cancer: *Have any of your blood relatives ever had cancer? Please include as much information about the cancer as you know.*

Relative	Type of Cancer	Age at Diagnosis	Current Age	Age at Death	Recurrence of cancer? Second Cancer diagnosis? Genetic Testing?
You					
Mother					
Mother's Mother					
Mother's Father					
Father					
Father's Mother					
Father's Father					
Brother or Sister					
Brother or Sister					
Brother or Sister					
Child ☐Male ☐Female					
Child ☐Male ☐Female					
Other Blood Relative:					
Other Blood Relative:					

Patient Name: _____

ID #: _____

Other Family Medical Conditions: *Please list any family members who have had the following medical problems.*

Condition	Relative
Diabetes	
High Blood Pressure	
Heart Disease	
Stroke	
Psychiatric Problems	
Substance Abuse	
Other	

Have you ever had a colonoscopy? ☐ Yes ☐ No When _____

Have you ever received a **blood transfusion**? ☐ Yes ☐ No When _____

Do you have a living will? ☐ Yes ☐ No

Do you have a durable power of attorney? ☐ Yes ☐ No

Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No

** If yes to any of the above, please provide a copy for your medical record.

OTHER MEDICAL PROBLEMS - not described above

_____

_____

_____

_____

SHOTS

When was your last Tetanus shot? Year_____ ☐ Never ☐ I don't know

When was your last Pneumonia shot? Year_____ ☐ Never ☐ I don't know

When was your last Flu shot? Year_____ ☐ Never ☐ I don't know

FOR WOMEN ONLY

Have you ever been **pregnant**? ☐ Yes ☐ No

How many times? _____

How many children have you given birth to? _____

Have you had a **PAP smear**? ☐ Yes ☐ No

Date of last one _____

Have you ever had a **PAP smear that was not normal**? ☐ Yes ☐ No

Have you had a **mammogram** (breast x-ray)? ☐ Yes ☐ No

Date of last one _____

Patient Name: _____

ID #: _____

SOCIAL HISTORY

Current Occupation/Employer:_____ Type of work: _____

Have you been exposed to any chemicals (toxic fumes, asbestos, etc?) ☐ Yes ☐ No

Have you ever smoked cigarettes, cigars, used snuff, or chewed tobbacco?

☐ Yes (If yes, complete the following) ☐ No

a. When did you start?_____

b. What type? _____

c. How much per week? _____

d. Have you quit? ☐ Yes ☐ No When? _____

e. Do you want to quit? ☐ Yes ☐ No ☐ Already Quit

Do you drink alcohol?

☐ Yes (If yes, complete the following) ☐ No

a. _____ beer per: ☐ day ☐ week ☐ month

b. _____ glasses of wine per: ☐ day ☐ week ☐ month

c. _____ mixed drinks per: ☐ day ☐ week ☐ month

d. Any prior or current history of alcohol abuse? ☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes (If yes, complete the following) ☐ No

a. When did you start?_____

b. What type? _____

c. How much per week? _____

d. Have you quit? ☐ Yes ☐ No When? _____

e. Do you want to quit? ☐ Yes ☐ No ☐ Already Quit

MEDICATIONS - Please list all medications, including prescription, over the counter, vitamins, supplements, and herbs.

Name	Dose	# times per day
Example: Aspirin	Example: 325 mg	Example: once daily

SURGERIES - Please list all surgeries and dates below.

_____

_____

_____

_____

ALLERGIES - Please list all drugs, food and environmental allergies, including latex powders, etc. that you have an allergy to.

Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	

PRIVACY NOTICE

Upon arrival at the office on the day of your first appointment, you will be asked to sign off on the Penn State Health Medical Group Notice of Privacy Practices. This document is posted at the front desk in each office for you to view. You may request a complete copy for your reference.

Penn State Health Medical Group
Andrews Patel Hematology/Oncology
Pain Management Agreement

Introduction

Our philosophy is pain reduction and pain management. For certain individuals, controlled substances can help control pain and return them to more functional living. Controlled substance use is under the control of several regulatory agencies. Physicians need to strictly abide by the local, state, and federal regulations when prescribing controlled substances. Thus, our physicians have developed the following standards of conduct for our patients.

Patient Obligations – Standards of Conduct

- I will communicate fully with my doctor about my pain and response to treatment.
- I will not use any illegal controlled substances, including marijuana, cocaine etc.
- I will not share, sell, or trade my medications with anyone.
- I will safeguard my pain medicine from loss or theft. **I understand that lost or stolen medications will not be replaced until time for the next fill.**
- I will not attempt to obtain controlled medications from any other doctor or pharmacy that are being prescribed by Andrews and Patel Associates, P.C.
- **I understand that refills of my pain medicine will be made only during regular office hours.**
- I understand that it may take 3-5 business days for refill of medications and I will call in advance for refills to allow for this.
- I agree to submit to a blood or urine test if requested by my doctor to determine compliance with my pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time (in other words – a request for a refill too soon may not be granted).
- I will bring all unused pain medicine to every office visit if requested by my physician.

Summary

Long term pain management depends on adherence to the above principles and maintenance of an effective doctor-patient relationship. I understand that:

- cessation of pain management therapy will be at the discretion of the physician
- this agreement may be shared with other health care providers
- if I break this agreement, my doctor may stop prescribing pain medications

During your first office visit, you will be asked to electronically sign our Pain Management Agreement acknowledging that you have read it. A copy is available for review at the front desk as well.

PennState Health Medical Group

ANDREWS PATEL HEMATOLOGY/ONCOLOGY

Life is unpredictable, don't get caught unprepared. Regardless of your age or health, it's important to make your wishes known.

Regardless of your age, diagnosis or health conditions, we encourage all patients to make their wishes formally known. This is often done through preparation of an advance directive. An advance directive will provide guidance should their come a time in the future when you are unable to express your wishes for care.

While this subject is quite sensitive, it is also extremely important. We find that it is much easier for patients and families to discuss these issues before an urgent need arises. Having your wishes known will give you and your family peace of mind knowing that they are following your wishes.

If you have questions about completing an advance directive, please reach out to the social worker in the office; as she can offer guidance.

Our staff has the utmost respect for every patient, and we are honored to serve you. We strongly encourage advance directives, so that your wishes are clear and can be respected, if the need arises. We understand that this can be an extremely difficult subject to discuss. Please know we are here to help. Our physicians will continue to have open, honest and respectful discussions with you and your loved ones. Our social work staff will continue to provide you with assistance during periods of time that may seem difficult or confusing. Please know that you are not alone and that we can help by discussing any questions or concerns.

PennState Health

PATIENT NAME:_____

DOB:_____ MRN #:_____

OR MUST PLACE FIN LABEL HERE

CONSENT TO TREATMENT AND PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

☐ Milton S. Hershey Medical Center ☐ Hampden Medical Center ☐ Penn State Health Life Lion, LLC
☐ St. Joseph Medical Center ☐ Lancaster Medical Center ☐ Holy Spirit Medical Center
☐ Pennsylvania Psychiatric Institute ☐ Penn State Health Community Medical Group, LLC
☐ Other: _____

MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned is under the care of his/her attending physician(s) and hereby consents to and authorizes Penn State Health (PSH) to provide the necessary medical treatments (including Emergency Department services), surgical procedures, anesthesia, x-ray examinations or treatments, laboratory procedures, telemedicine services, drugs and supplies to the patient as ordered or requested by the Professional Clinical Staff of the PSH. I acknowledge that no guarantee or assurance has been made as to the results of medical treatments, surgeries, or examinations. For the purpose of advanced medical knowledge, I consent to the presence of medical students and other health care trainees. I understand they may participate in my care under the direct supervision of my attending physician(s). I understand that should I require medical treatment in the resuscitation (trauma) bay, my treatment may be recorded (audio visual recording) for quality assurance purposes. I acknowledge that these recordings may be reviewed by the Emergency Department/Trauma Team(s) however will not become part of my medical record and will be erased after review.

CONSENT TO ACCESS, REVIEW AND RETAIN PREVIOUS PRESCRIPTION MEDICATION INFORMATION: I consent to and authorize PSH healthcare providers to access and review any of my electronic prescription medication history information which may be available through Surescripts Database, including but not limited to, prescriptions ordered and/or filled for me at any pharmacy which participates in the Surescripts Database. I understand that this historical prescription information will then become a permanent part of my electronic medical record at PSH.

PATIENT'S RIGHTS AND RESPONSIBILITIES: I acknowledge that PSH has provided me with written information on my rights and responsibilities as a patient. I am aware that a Patient Representative is available to me if I have additional questions or otherwise wish to speak with one.

MEDICAL RECORD RELEASE AUTHORIZATION: I acknowledge that the PSH Privacy Notice has been made available to me. I understand that PSH may disclose information about me and the treatment I am receiving, for purposes of continuous treatment, payment and health care operations.

ASSIGNMENT OF BENEFITS: I assign and authorize payment directly to PSH. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents and/or to any entity with which PSH contracts to provide clinical services to its patients, any information needed to determine these benefits or benefits for related services.

INDIVIDUAL FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for my health insurance deductible, coinsurance, and co-payments which are payable at the time of service. If my health insurance requires a referral, I must obtain the referral and present it at the time of my visit. In the event my health insurance determines a service to be "not payable," I will be responsible to pay for the charge(s) for all services provided. If I do not have health insurance or my health insurance cannot be verified, I agree to pay for the medical services rendered to me at time of service.

CONSENT TO eCONSULT REVIEW OF MEDICAL RECORDS AND INDIVIDUAL FINANCIAL RESPONSIBILITY: I consent to Penn State Health providers who have not previously been directly involved in my treatment to access and use my electronic medical record for the purpose of consulting with my treating physician through Penn State Health's electronic platform (eConsults). I understand that eConsults are used when my treating provider requests the opinion and/or advice of another healthcare professional with specific expertise to assist in the diagnosis and management of my condition. I also understand that the eConsults will take place through electronic communications media, such as Penn State Health's Electronic Medical Record system, Cerner's CareConnect. This process may reduce wait time for determining details on my diagnosis/condition and give my treating provider a better understanding of how to best manage my condition. I understand this consultation may be performed by providers I have not treated with previously and although I will have no direct contact with the provider for the purpose of this consult, there may be an associated fee for which I am responsible.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

_____ _____
Borrower/Customer Signature *Date*

I, the undersigned, certify that I have read, understand, and agree to the provisions contained within the consent form. The issues addressed on this form have been fully explained to me. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

_____ _____
Patient's Signature (or signature of person consenting on behalf of the patient) *Date / Time* *AM / PM*

_____
Printed Name of person signing above

_____
Relationship to the patient, if applicable

_____ _____
Witness to Patient's Signature *Date / Time* *AM / PM*

CONSENT TO TREATMENT AND PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT