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
Heather Cassatt
Practice Site Manager

355 N. 21st Street
Suite 301
Camp Hill, PA 17011
P: 717-798-3720
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Rita Overcash, MHA, BSN, RN
Assoc. Director Ambulatory Practices
Penn State Health Medical Group
Community Practice Division

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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 at the front of the building.
- ☐ 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

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 ☐ Other: _____
☐ Holy Spirit Medical Center ☒ Penn State Health Community Medical Group, LLC

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

PennState Health

Patient Rights & Responsibilities

As a patient of this practice, or as a family member or guardian of a patient of this practice, we want you to know the rights you have under federal and Pennsylvania state law. We are committed to honoring your rights, and want you to know that by taking an active role in your health care, you can help your caregivers meet your needs as a patient or family member. That is why we ask that you and your family share with us certain responsibilities.

Your Rights

As a patient, you or your legally responsible party have the right to receive care without discrimination due to age, sex, race, color, religion, sexual orientation, income, education, national origin, ancestry, marital status, culture, language, disability, gender identify, or who will pay your bill. As our patient, you have the right to safe, respectful, and dignified care at all times. You will receive services and care that are medically suggested and within the practice's scope of services, our stated mission, and required laws and regulations. Please feel free to ask questions about any of these rights that you do not understand. If you have questions about these rights, please discuss them with your doctor, nurse, or the practice manager. You will receive a personal response.

Communication

You have the right to:

- Have a family member, another person that you choose, or your doctor notified when you are admitted to the hospital.
- Receive information in a way that you understand. This includes interpretation and translation, free of charge, in the language you prefer for talking about your health care. This also includes providing you with needed help if you have vision, speech, hearing, or cognitive impairments.
- Designate a support person, if needed, to act on your behalf to assert and protect your patient rights.

Informed Decisions

You have the right to:

- Receive information about your current health, care, outcomes, recovery, ongoing health care needs, and future health status in terms that you understand.
- Be informed about proposed care options including the risks and benefits, other care options, what could happen without care, and the outcome(s) of any medical care provided, including any outcomes that were not expected. You may need to sign your name ("informed consent") before the start of any procedure and/or care. Informed consent is not required in the case of an emergency.
- Be involved in all aspects of your care and to take part in decisions about your care.
- Make choices about your care based on your own spiritual and personal values.
- Request care. This right does not mean you can demand care or request services that are not medically needed.
- Refuse any care, therapy, drug, or procedure against the medical advice of a doctor. There may be times that care must be provided based on the law.
- Expect the practice to get your permission before taking photos, recording, or filming you, if the purpose is for something other than patient identification, care, diagnosis, or therapy.
- Decide to take part or not take part in research or clinical trials for your condition, or donor programs that may be suggested by your doctor. Your participation in such care is voluntary, and written permission must be obtained from you or your legal representative before you participate. A decision to not take part in research or clinical trials will not affect your right to receive care.

Care Delivery

You have the right to:

- Receive care in a safe setting free from any form of abuse, harassment, and neglect.
- Receive kind, respectful, safe, quality care delivered by skilled staff.
- Know the names of doctors and nurses providing care to you and the names and roles of other health care workers and staff that are caring for you.
- Receive proper assessment and management of pain, including the right to request or reject any or all options to relieve pain.
- Receive efficient and quality care with high professional standards that are continually maintained and reviewed.

Privacy and Confidentiality

You have the right to:

- Limit who knows about your being in the practice.
- Be interviewed, examined, and discuss your care in places designed to protect your privacy.
- Be advised why certain people are present and to ask others to leave during sensitive talks or procedures.
- Expect all communications and records related to care, including who is paying for your care, to be treated as private.
- Receive written notice that explains how your personal health information will be used and shared with other health care professionals involved in your care.
- Review and request copies of your medical records unless restricted for medical or legal reasons.

Medical Bills

You have the right to:

- Review, obtain, request, and receive a detailed explanation of your medical charges and bills.
- Receive information and counseling on ways to help pay for your medical bills.
- Request information about any business or financial arrangements that may impact your care.

Complaints, Concerns, and Questions

You and your family/guardian have the right to:

- Tell practice staff about your concerns or complaints regarding your care. This will not affect your future care.
- Seek review of quality of care concerns, coverage decisions, and concerns about your discharge.
- Expect a timely response to your complaint or grievance from the practice. Complaints or grievances may be made in writing, by phone, or in person. The practice has a duty to respond to these complaints or grievances in a manner that you can understand. To share your concerns with the practice, please contact the manager of your practice.
- The Pennsylvania Department of Health is also available to assist you with any questions or concerns about the care you receive at the practice. You can reach the Department of Health by calling (800) 254-5164 or writing to: Acute and Ambulatory Care Services, Pennsylvania Department of Health, Room 532, Health and Welfare Building, 625 Forster Street, Harrisburg, PA 17120.

Continued...

PennState Health

Patient Rights & Responsibilities *continued*

Your Responsibilities

As a patient, family member, or guardian, you have the right to know all practice rules and our expectations of you during your visit.

Provide Information

As a patient, family member, or guardian, we ask that you:

- Provide accurate and complete information about current health care problems, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Report any condition that puts you at risk (for example, allergies or hearing problems).
- Report unexpected changes in your condition to the health care professionals taking care of you.
- Provide a copy of your Advance Directive, Living Will, Durable Power of Attorney for health care, and any organ/tissue donation permissions to the health care professionals taking care of you.

Respect and Consideration

As a patient, family member, or guardian, we ask that you:

- Recognize and respect the rights of other patients, families, and staff. Threats, violence, or harassment of other patients and practice staff will not be tolerated.
- Comply with the practice's no smoking policy.
- Refrain from conducting any illegal activity on practice property. If such activity occurs, the practice will report it to the police.

Safety

As a patient, family member, or guardian, we ask that you:

- Promote your own safety by becoming an active, involved, and informed member of your health care team.
- Ask questions if you are concerned about your health or safety.
- Make sure your doctor knows the site/side of the body that will be operated on before a procedure.
- Remind staff to check your identification before medications are given, blood/blood products are administered, blood samples are taken, or before any procedure.
- Remind caregivers to wash their hands before taking care of you.
- Be informed about which medications you are taking and why you are taking them.
- Ask all practice staff to identify themselves.

Refusing Care

As a patient:

- You are responsible for your actions if you refuse care or do not follow care instructions.

Charges

As a patient:

- You are responsible for paying for the health care that you received as promptly as possible.
- Penn State Health is proud of its mission to provide excellent service to all our patients and their families. If payment of your medical bill is a concern, we may be able to assist you.
- We provide financial assistance based on income, family size and assets for medically necessary and emergent services. Patients who are eligible for financial assistance will not be charged more than the amounts generally billed to patients with insurance. Please visit our website at hmc.pennstatehealth.org to access our Financial Assistance Policy and financial assistance applications. Documents are translated in various languages and are available on the website or in person. Patient Financial Services is conveniently located on the campus of the Milton S. Hershey Medical Center, Academic Support Building, 90 Hope Drive, 2nd floor, Suite 2106 or available by phone at 717-531-5069 or 1-800-254-2619.

Cooperation

As a patient:

- You are expected to follow the care plans suggested by the health care professionals caring for you at the practice. You should work with your health care professionals to develop a plan that you will be able to follow.

Nondiscrimination Notice

The Pennsylvania Department of Health complies with and enforces the laws and regulations which prohibit discrimination against employees and persons receiving services in facilities regulated by the Department. Facilities and programs operated by, or services contracted with or paid for with funds provided by, the Commonwealth of Pennsylvania, Medicare or Medicaid, shall be provided without discrimination due to a person's race, color, religious creed, ancestry, union membership, age, gender, sexual orientation, gender identify or expression, national origin, AIDS or HIV status or disability.

CIVIL RIGHTS COMPLAINTS INVOLVING NURSING HOME RESIDENTS
Division of Nursing Care Facilities
Room 526 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Phone: (717) 787-1816
Fax: (717) 772-2163
Complaint Hot-line: 1-800-254-5164
www.portal.state.pa.us/portal/server.pt/community/complaint_form/20164

CIVIL RIGHTS COMPLAINTS INVOLVING PATIENTS IN HOSPITALS, AMBULATORY SURGICAL CENTERS, AND ABORTION FACILITIES:

Division of Acute & Ambulatory Care
Room 532 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Phone: (717) 783-8980
Fax: (717) 705-6663
Complaint Hot-line: 1-800-254-5164
www.portal.state.ps.us/portal/server.pt/community/compliant_form/20164

CIVIL RIGHTS COMPLAINTS INVOLVING PATIENTS OF HOME HEALTH AGENCIES, HOME CARE AGENCIES, BIRTH CENTERS PEDIATRIC EXTENDED CARE CENTERS, HOSPICE AGENCIES/CENTERS, END STAGE RENAL DISEASE FACILITIES, RURAL HEALTH CENTERS, OUTPATIENT PHYSICAL THERAPY FACILITIES AND COMPREHENSIVE OCCUPATIONAL REHABILITATION FACILITIES.

Division of Home Health
132 Kline Plaza Suite A
Harrisburg, PA 17104
Phone: (717) 783-1379
Fax: (717) 772-0232
Complaint Hot-line: 1-800-254-5164
www.portal.state.pa.us/portal/server.pt/community/complaint_form/20164

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.