Panhandle Cancer Care Center
Affiliate of Amarillo Urology Associates, LLP
A New Light • A New Hope

Panhandle Cancer Care Center
1301 S. Coulter Suite 100
Amarillo, TX 79106
Phone(806)354-0950
Fax (806)356-1935

PATIENT FINANCIAL POLICY SHEET

To reduce confusion and misunderstanding between our patients, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing and insurance office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard, Discover and American Express.

Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Billing:

- All billing statements from Panhandle Cancer Care Center will fall under the provider name Amarillo Urology Associates since we are associated with their practice. If you are mailing in a payment please make a note on the check that it is for Dr. Stafford.

Minors:

- For all services rendered to minor patients, the parent or guardian will be responsible for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor **Date**

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NOTICE OF PRIVACY PRACTICES

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

X_____

Signature of Patient or Personal Representative

_____/_____/_____

Date

_____

Name of Patient or Personal Representative

(Printed Name)

_____

Personal Representative relationship to Patient

(Printed Name)

I authorize that my medical information can be released as follows:

Information to be released to:

_____

Name/Relationship to Patient/Phone #

(Printed Name)

X_____

Signature of Patient

_____/_____/_____

Date

Information to be released to:

_____

Name/Relationship to Patient/Phone #

(Printed Name)

X_____

Signature of Patient

_____/_____/_____

Date

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James H. Stafford, M.D.

PRESCRIPTION MEDICATION NOTICE

Due to the rapidly changing policies and drug formularies of insurance companies, we are unable to assist with the pre-authorization requests being made by them. Your prescription drug coverage is a contract between you and your insurance provider. You, the patient must contact your insurance company to obtain pre-authorization if needed.

If we are notified a pre-authorization is required, we will direct your pharmacy to contact you. They can provide you with the phone number needed to obtain the pre-authorization. We will provide you with a copy of your chart note indicating the medication ordered and the reason for the order.

*******THIS OFFICE DOES NOT REFILL PRESCRIPTIONS PRESCRIBED BY OTHER PHYSICIANS*******

_____
Signature of Patient or Personal Representative

_____/_____/_____
Date

_____
Name of Patient or Personal Representative
(Printed Name)

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Patient Name: _____

PATIENT COMMUNICATION INFORMATION

Due to the fact that we have electronic medical records, we have the ability to provide you with your health information in a variety of ways.

Please choose a delivery method for each of the following categories:

You do not have to choose any of the delivery methods from the categories below and you may choose **NONE** as an option.

Please only choose one delivery method for each category

	Print Copy	E-Mail	Portable Media (USB or CD	Patient Portal (online access to your information)	Text Message	None
Patient Health Information						
Appointment Reminders						
Visit Summary						

If you choose Patient Portal you will be given instructions after your appointment on how to access the system.

Please provide the following information to keep our records current:

E-Mail Address: _____

Cell Phone #:_____

Cell Phone Carrier	AT&T	Sprint	Verizon	Cellular One	T-Mobile

Other cell phone carrier not listed above:_____

If you have any questions, please don't hesitate to ask for assistance.

Thank You,

Panhandle Cancer Care Center Staff

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REVIEW OF SYSTEMS

NAME: **PC3 #:**

ALLERGIES			**EYES**		
DRUGS	Y	N	BLURRED VISION	Y	N
ENVIRONMENTAL	Y	N	DOUBLE VISION	Y	N
CARDIOVASCULAR			GLASSES	Y	N
			READING GLASSES	Y	N
IRREGULAR HEARTBEAT	Y	N	**GI**		
CHEST PAIN	Y	N	ABDOMINAL PAIN	Y	N
SWELLING	Y	N	HEARTBURN	Y	N
CONSTITUTIONAL			**GENITOURINARY**		
POOR APPETITE	Y	N			
FATIGUE	Y	N	PAINFUL URINATION	Y	N
FEVER	Y	N	FREQUENCY	Y	N
CHILLS	Y	N	BLOOD	Y	N
WEIGHT CHANGE	Y	N	URGENCY	Y	N
ENDOCRINE			INCONTINENECE	Y	N
DIABETES	Y	N	**HEM/LYMPH**		
THYROID PROBLEMS	Y	N	BLEED EASILY	Y	N
ENMT			TENDER LYMPH NODES	Y	N
TROUBLE SWALLOWING	Y	N	**SKIN**		
DIFFICULTY HEARING	Y	N			
HEARING AIDS	Y	N	BLISTERS	Y	N
SORE THROAT	Y	N	PERSISTENT ITCH	Y	N
SINUS PROBLEMS	Y	N	RASH	Y	N
MUSCULOSKELETAL			**NEUROLOGICAL**		
ARTHRITIS	Y	N	DIZZINESS	Y	N
BONE PAIN	Y	N	BALANCE PROBLEMS	Y	N
JOINT PAIN	Y	N	HEADACHE	Y	N
BACK PAIN	Y	N	MEMORY LOSS	Y	N
MUSCLE WEAKNESS	Y	N	TREMORS	Y	N
RESPIRATORY			**PSYCHIATRIC**		
COUGH	Y	N			
SHORTNESS OF BREATH	Y	N	DEPRESSION	Y	N
WHEEZING	Y	N	ANXIETY	Y	N

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PATIENT HISTORY FORM

NAME:_____ **DATE OF BIRTH:**_____ **TODAY'S DATE**_____

MEDICAL PROBLEMS: DO YOU CURRENTLY HAVE OR HAVE HAD A HISTORY OF ANY OF THE FOLLOWING PROBLEMS? PLEASE CHECK ALL THAT APPLY.

ASTHMA	☐	HIGH CHOLESTEROL	☐
ATRIAL FIBRILLATION (A-FIB)	☐	HYPERTENSION	☐
CARDIOVASCULAR DISEASE	☐	KIDNEY STONES	☐
DIABETES	☐	OSTEOARTHRITIS	☐
EMPHYSEMA	☐	OTHER CANCER(S)	☐
GASTRIC REFLUX	☐	RHEUMATOID ARTHRITIS	☐
GLAUCOMA	☐	SEIZURES	☐
HEART ATTACK	☐	STROKE	☐
HEART DISEASE	☐	THYROID PROBLEMS	☐

OTHER:_____

_____

SURGICAL PROCEDURES: PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR THEY WERE PERFORMED.

_____

_____

FAMILY HISTORY: PLEASE LIST ANY HISTORY OF DIABETES, HEART DISEASE, OR CANCER IN YOUR FAMILY MEMBERS (PLEASE INCLUDE RELATIONSHIP TO YOU -- i.e. FATHER, MOTHER, BROTHER, SISTER, ETC.)

_____

_____

SOCIAL HISTORY:

DO YOU SMOKE? YES: ☐ **NO:** ☐ **IF YOU ANSWERED YES, HOW MANY PACKS PER DAY DO YOU SMOKE?** _____

DO YOU HAVE A HISTORY OF SMOKING? YES: ☐ **NO:** ☐

AT WHAT AGE DID YOU START SMOKING? _____ **WHEN DID YOU QUIT SMOKING?** _____

IF YOU HAVE QUIT SMOKING, HOW MANY PACKS PER DAY WERE YOU SMOKING? _____

DO YOU DRINK ALCOHOL? _____ **HOW MANY DAYS PER WEEK?** _____ **DRINKS PER DAY?** _____

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PATIENT HISTORY FORM CONTINUED

PLEASE LIST DATES FOR THE APPLICABLE SCREENING TESTS:

MOST RECENT COLONOSCOPY: _____

RESULTS OF MOST COLONOSCOPY: CIRCLE ONE: NEGATIVE or POSITIVE for COLON CANCER

MOST RECENT MAMMOGRAM: _____

RESULTS OF RECENT MAMMOGRAM: CIRCLE ONE: NEGATIVE or POSITIVE for BREAST CANCER

MOST RECENT PAP TEST (FEMALE PATIENTS ONLY): _____

RESULTS OF RECENT PAP TEST: CIRCLE ONE: NEGATIVE or POSITIVE for CERVICAL CANCER___

ALLERGIES: PLEASE CHECK APPLICABLE BOX AND PROVIDE AN EXPLANATION OF REACTION (i.e. – RASH, SWELLING, SHORTNESS OF BREATH, VOMITING, ETC.)		
DRUG	☐	
FOOD	☐	
ENVIRONMENTAL	☐	
OTHER	☐	

DO YOU HAVE AN ADVANCE DIRECTIVE? **YES:** ☐ **NO:** ☐

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? **YES:** ☐ **NO:** ☐

IN CONSIDERATION OF YOUR FELLOW PATIENTS AND OUR STAFF, PLEASE ANSWER THE FOLLOWING QUESTION:

ARE YOU AWARE OF THE PRESENCE OF BED BUGS IN YOUR HOME? YES: ☐ **NO:** ☐

IF YES, WE MAY HAVE THE RESOURCES TO HELP YOU ERADICATE THEM. PLEASE DO NOT HESITATE TO ASK. WE ARE HERE TO HELP.

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NAME:_____ DATE:_____

It is important for us to know each medication you are currently taking. This includes medications that have been prescribed by all your physicians, over-the-counter medications, vitamins, supplements, herbal medications, and any others you take on a regular basis. Please list all medications in the section below. Please double check that the frequency and strength is accurate for all current medications listed below. If you need more room, please list additional information on the back of this page. Thank you for taking the time to fill out this information.

NAME OF MEDICATION	STRENGTH	HOW OFTEN DO YOU TAKE IT
Example: Aspirin	81 mg	One tablet per day

Have you received a FLU shot within the last 12 months? YES: ☐ NO:☐
If yes, when? Month_____ Year_____ If no, please list reason_____

Have you received PNEUMONIA vaccine? YES: ☐ NO:☐
If yes, when? Month_____ Year_____

Have you received the SHINGLES vaccine? YES: ☐ NO:☐
If yes, when? Month_____ Year_____

Have you had the COVID vaccine YES: ☐ NO:☐
If yes, when? Month_____ Year_____

Have you had COVID YES: ☐ NO:☐
If yes, when? Month_____ Year_____

Signature:_____