San Juan Oncology Associates
Hematology Oncology and Research

NEW PATIENT INFORMATION

Name: _____ DOB_____ Date: _____

DRUG NAME	DOSE	FREQUENCY	START DATE (M/D/Y)

Referring Physician: _____ Primary Care Physician: _____

Do you have any medical devices or home oxygen? Yes___ No___ Please Specify _____
Are you ALLERGIC to any medications? Yes ___ No ___ List _____

Please list any illness (es) you have had which required a physician's care, with dates:

Date:	Illness:	Date:	Illness:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all surgeries with dates:

Date:	Surgery	Date:	Surgery:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HISTORY:

Marital status ___ Married ___Single ___ Divorced ___ Separated____ Widow/er
Tobacco use: ___ None Packs per day ___ Started (age) ___ Stopped (age) ___
Alcohol Use: ___ None Drinks per day ___
Exercise habits: ___ No regular program ___ Regular program – describe _____
Special diets: ___ Yes ___ No Please describe: _____
Occupation: _____. If retired, please list your previous occupation: _____
Educational Level: ___ Elementary School ___ Middle School ___ High School
___ College Undergraduate ___ Masters ___ Doctorate
Religious Preference: _____
Do you have any beliefs that would impact medical care or treatment? _____
Are you interested in support groups or counseling services? Yes ___ No ___
Pain: Are you in pain today? Yes ___ No ___. If yes, where? _____
On a scale of 0-10, 0 being the absence of pain and 10 being the worst imaginable pain, circle the number that best describes your pain: 0 1 2 3 4 5 6 7 8 9 10

MA Signature _____ **MD Initials** _____

FAMILY HISTORY:

	Father	Mother	Brothers	Sisters
Age				
Age at death				
Cause of death				

Any history of cancer or blood disease in your family? If yes, who? _____

REVIEW OF SYSTEMS: (Check yes or no and all that apply) (COMMENT section for MA to complete)

Not including night sleep, what part of the day do you spend in bed?
More than 50%_____ Less than 50%_____ None_____

Constitutional: ___ fever ___ night sweats
COMMENTS: _____

Weight loss _____ Yes _____ No How much? _____
COMMENTS: _____

Eyes: ___ glasses/contacts ___ cataracts ___ pain ___ redness
COMMENTS:_____

Nose/ ___ sinus pain ___ drainage ___ bleeding ___ hay fever
Mouth/throat ___ soreness ___ redness ___ hoarseness
___ difficulty swallowing ___ painful swallowing
Last dental exam: _____
COMMENTS: _____

Respiratory: ___ chest pain ___ wheezing ___ cough ___ bronchitis ___ asthma
___ shortness of breath ___ pneumonia ___ TB history ___ emphysema
Sputum color: _____ Amount: _____
Date of last chest x-ray: _____
COMMENTS: _____

Cardiac: ___ chest pain ___ rheumatic fever ___ palpitations ___ murmur
___ hypertension ___ dizziness ____ blood clots ____ heart tests
___ shortness of breath ____ swelling of feet and ankles
COMMENTS: _____

Gastrointestinal: ___ decreased appetite ___ nausea ___ vomiting ___ diarrhea
___ indigestion ___ rectal bleeding ___ hemorrhoids ___hepatitis
___ constipation ___ abdominal pain ___ dark stools ___ jaundice
COMMENTS: _____

Urinary: ___ history of stones ___lack of control ___ infections
___ bleeding ___ frequent, painful urination ___ difficulty starting stream
How many times do you void at night? _____
COMMENTS: _____

Musculoskeletal: ___ joint pain ___ stiffness ___arthritis ___ gout
___ activity limitation ___ backache ___ muscle pain ___ cramps
COMMENTS: _____

MA Signature _____ **MD Initials _____**

Skin: ___ contact allergies ___ itching ___ changes in hair ___skin rash
___ breast lumps ___ breast cysts ___ nipple discharge/bleeding
___ fibrocystic breast changes Date of last mammogram: _____
COMMENTS: _____

Neurological: ___ fainting ___ blackouts ___ seizures ___ tingling
___ tremor ___ weakness ___ numbness
COMMENTS: _____

Emotional: ___ nervousness ___ headache ___ depression ___ sleeplessness
COMMENTS: _____

Endocrine: ___ thyroid problems ___ diabetes ___ heat/cold intolerance
Increased frequency of: ___ urination ___ thirst
COMMENTS: _____

Hematologic: ___ anemia ___ easy bruising ___ history of transfusions
___ bleeding after surgery ___H IV/AIDS ___ Hepatitis
COMMENTS: _____

Immunologic: ___ history of frequent infections? Please explain: _____
COMMENTS: _____

OB/GYN Women: ___ heavy menses ___ painful menses ___ menopausal symptoms
Method of birth control: _____
Age at first period: _____ Age at last period: _____
Menopause - natural or surgical: _____. At what age: _____
Age at first pregnancy: ___ # of pregnancies: ____ # of deliveries ____
Date of last Pap smear: _____History of abnormal Pap smears? Yes ___ No ___
Have you ever taken hormone therapy or birth control pills? Yes ___ No ___
Do you have any concerns about sexual dysfunction? Yes ___ No _____
COMMENTS: _____

Men: ____Prostate condition ___ Impotence ___ History of abnormal PSA
Do you have any concerns about impotence and/or sexual dysfunction? ___ Yes____ No

COMMENTS: _____

MA initials _____ **MD initials _____**

Note: If you believe your current symptoms require timely assessment, please ask your referring physician to call us to request a high priority appointment.

San Juan Oncology Associates
Hematology Oncology and Research

PATIENT INFORMATION

Name_____ SS#_____Gender_____DOB_____
Marital Status (Circle One): Single Married Widow/er Separated
Language Spoken: _____ Ethnicity: _____
Mailing address: _____City _____State ____Zip_____
Physical address: _____City _____State _____Zip_____
Phone: (H)_____ (C) _____Email:_____
How would you prefer we contact you? Cell Phone Home Phone Work Phone Email Mail
Primary Care Physician_____ Referring Physician _____
Other Physicians Involved in Your Care _____
Preferred Pharmacy_____

INSURANCE INFORMATION

Primary Insurance Company_____
Subscriber's Name _____ Relationship to Patient: Self Spouse Other
DOB: _____ SS#_____
Secondary Insurance Company: _____
Subscriber's Name _____ Relationship to Patient: Self Spouse Other
Subscriber's DOB: _____SS#_____
Subscriber's Address (if different from above) _____

EMPLOYMENT INFORMATION

Occupation: _____If retired, please list your previous occupation _____
Educational Level: ___ Elementary School ___ Middle School ____High School
___College ___Undergraduate ___Masters ___Doctorate
Patient's Employer: _____ Phone _____
Address:_____ City_____
State_____ Zip_____
Spouse's Employer: _____ Phone: _____
Address_____City_____State_____Zip_____

EMERGENCY CONTACT INFORMATION

In case of an emergency please notify _____ Relationship: _____
Phone: _____
Approved contact (s) that we may discuss your health and treatment with:

Name:_____Relationship: _____

Patient Signature: _____Date: _____

San Juan Oncology Associates
Hematology Oncology and Research

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

To: _____

Fax: _____

Date Requested: _____

RECORDS REQUESTED

_____

_____

_____

_____

The above referenced patient has an appointment in our clinic. In order to facilitate patient's care, we need to have his/hers records faxed to our clinic.

we appreciate your cooperation. Please fax records back to **505-564-6890.**

RELEASE OF INFORMATION AUTHORIZATION

_____, I hereby give my permission for the above referenced healthcare facility to release my medical information to Four Corners Cancer Center.

_____ _____

Signature Date

2325 E. 30TH ST, Farmington, NM 87401
Ph: 505-564-6850 • Fax: 505-564-6890 • www.sanjuanoncology.com

No Show Policy

Description

SJOA goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

PLEASE INITIAL EACH LINE, SIGN AND DATE POLICY

Procedure I.

_____ A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established patients:

_____ Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.

_____ In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens.

_____ In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from SJOA. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions, in accordance with SJOA guidelines.

III. New patients:

_____ Appointment must be cancelled at least 24 hours prior to scheduled appointment time.

_____ In the event of a no-show, SJOA will contact the referral office to inform about the not shows.

_____ In the event of three (3) documented "same-day cancellations," the patient may be subject to dismissal from SJOA. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions, in accordance with SJOA guidelines.

_____ _____
Signature & Date Date of birth

San Juan Oncology Associates
Hematology Oncology and Research

FINANCIAL POLICY

Patients have a right to receive information regarding fees and charges, including the right to request a summarized statement of charges and to obtain any additional information about such charges.

Patients are responsible for providing insurance information and working with San Juan Oncology Associates to make prompt payments.

Co-payment and Deductibles: Any co-pays and deductible amounts not covered by your insurance must be paid at check-in at the time of service.

Outstanding Balance: A past due account is an account where no payment has been received within thirty (30) days, at which point you will receive a statement during the first five (5) days of the month following the date of service.

Monthly Statement: If your account becomes past due, two (2) notices will be mailed to the address provided by you when registering as a patient at San Juan Oncology Associates. If no payment is received within ten (10) days from the date of notice, the account will be referred to a collection agency.

Minimum Payment: A minimum payment 40% of the total bill of $1,000 or more, must be made to an account that is past due. If the bill is under $1,000, then the bill must be paid in full. If the patient does not contact us in an effort to make payment arrangements, the account will be considered delinquent and referred to a collection agency.

Payment Options: Payments must be made at check in on the day treatment is rendered. Payments may be made by cash, check or credit card. If a check is returned by the bank, the patient is responsible for an administrative fee of thirty ($30.00) dollars, payable to SJOA by cash or credit card.

Release of Medical Information and Assignment of Benefits: By signing above, I authorize the release of medical information necessary for filing health insurance claim forms for me by San Juan Oncology Associates and its Physicians. I also authorize my insurance carriers to make payment directly to them.

San Juan Oncology recognize the unique and unanticipated nature of medical expenses; however, we are unable to provide treatment free of charge, we are nonetheless willing to assist you with financial counseling where patient assistance programs will be presumed and reasonable payment arranges will be explained.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES 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.

At San Juan Oncology Associates, PC, we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. We are required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We abide by the terms in the Notice of Privacy Practices in effect at the time it is provided to you.

As a patient, you have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically.

San Juan Oncology Associates will not use or disclose your individually identifiable or protected health information other than to carry out healthcare treatment, payment, and/or operations for you, or as required by law.

An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, laboratory and pharmacy technicians, medical assistants and others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or a third party that may be responsible for collecting payment from a health plan. Healthcare operations means sharing protected health information for the purpose of quality review. We will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate healthcare operations of our practice, to facilitate the requirements of our business associates' contracts, and to comply with requests from other covered entities to carry out treatment, payment or healthcare operations.

Except for the purposes described above, San Juan Oncology Associates, PC, will only use or disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures. Any information San Juan Oncology Associates, PC, provides to a third party other than to our business associates or other healthcare providers with a treatment relationship to you will be de-identified of any and all personal data which could be used to identify a specific individual.

An appointment reminder service on behalf of San Juan Oncology Associates may contact you to provide information about your upcoming appointments.
Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization.

You may request that certain uses and disclosures of your protected health information be restricted. To do so, you must provide the request in writing. San Juan Oncology Associates will determine if the information constitutes required information to carry out treatment, payment or healthcare operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or healthcare operations, we will accept your request for restrictions and will notify you if your request will be honored within 30 days or as required by law.

San Juan Oncology Associates reserves the right to revise this Notice of Privacy Practices at any time without prior notification. You may request a copy of the revised notice and we will provide it to you. For additional information, please write us at:

San Juan Oncology Associates, PC
Attention: Griselda Neidhart
HIPAA Privacy Contact/Practice Manager
2325 E. 30TH St
Farmington, NM 87401
(505) 564-6850

Acknowledgment of receipt of Notice of Privacy Practices:

Please print your name, sign and date as acknowledgment of this form. Please return this notice to the receptionist. A copy will be made for you and the original of this document will be placed in your chart.

Printed Name: _____

Signature: _____

Date: _____

Rev. 9/2016

PRESCRIPTION REFILL POLICY

-No prescriptions will be filled on Saturdays, Sundays, holidays, or evenings.

- Our office requires 48 hours to process prescription(s) renewals, and/or pick-up requests. Urgent requests may be obtained on a case by case basis.

-The patient is responsible for knowing when medication(s) will need to be refilled

-Prescription phone-in/pick-up times are Monday – Fridays from 8:00 a.m. to 3:00 p.m.

-Drug screens will be done on the initial visit when a narcotic/controlled substance is given to the patient. They will also be done randomly as long as you are a patient with our office. If you are not compliant with this policy we will not refill your narcotic prescriptions.

-If your prescription is stolen or lost, a police report must be filed with no exceptions. Our office must be notified immediately of the lost/stolen medication, and the date it was lost/stolen. We will also require a copy of the police report before we are able to replace the prescription.

-Medications are prescribed for the individual's use ONLY! It's a violation of your pain management agreement to "share" your medication.

-Patient must pick up his/her prescription(s) in person, unless preauthorized by the staff.

These protocols are per the recommendations of DEA

We strive to offer the best services and care for each patient in a timely manner. The above rules are essential and necessary to efficiently manage a busy clinic.

Thank you in advance for your cooperation and understanding.

_____	_____
Patient Signature	Jeffery Neidhart, MD
_____	_____
Date	Sardar Zakariya Imam, MD
_____	_____
Date of Birth	Ankit Anand, MD

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I understand that my medication(s) will be refilled on a regular basis. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____ _____
Patient Signature & Date Sardar Imam, MD

_____ _____
Jeffery Neidhart, MD Ankit Anand, MD

San Juan Oncology Associates
Hematology Oncology and Research

FCCC
San Juan Oncology Associates
Oncology and Hematology Treatment & Research Center
Policy 1.4: Retention, Maintenance and Destruction of Medical Records
Effective Date: 4/15/2015
Revised Date: 11/21/2019

Purpose: To establish guidelines for the contents, maintenance, and confidentiality of patients Medical Records that meet the requirements set fourth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, wether in paper or electronic format, that comprises the medical record.

Policy: San Juan Oncology Associates (SJOA) ensures that the medical patient protected health record is maintained in a manner that is consistent with the legal requirements, current, standardized, detailed, organized and available.

A. Federal Requirements

The Centers for Medicare & Medicaid Services (CMS) require healthcare providers to retain patient records for Medicare beneficiaries for at least five (5) years. CMS requires Medicare managed care program providers to retain records for ten (10) years.

B. State Requirements

San Juan Oncology Associates, A New Mexico Professional Corporation must retain medical records for at least ten (10) years after the date of last treatment as set by state regulation.

Deceased patients' records must be kept for five (5) years from the date of death. After this timeframe, medical records will be removed from the electronic medical records (EMR) software and/or shredded accordingly.

If converted from paper to electronic form, SJOA must retain the hard copy of a record for a minimum of thirty (30) days after the electronic transfer has occurred.

Improper management of medical records violates §61-6-15. D (33).

C. Requesting Medical Records

Patients insurance carriers and physicians may request medical records or a transfer of records by contacting San Juan Oncology Associates at 505-564-6850 or faxing such a request 505-564-6890.

Records will be either mailed or faxed back to requesting party.

The cost for obtaining copies of medical records is of fifty cents (.50¢) per page or as SJOA management considers appropriate depending on the amount of time invested to obtain such records, if color copies and/or images are included in the file, etc.

Data backup plan, disaster recovery plan and storage will be handled as stated in policies 2.6 and 3.0 which ensures retrievability into reasonably usable form on a timely basis upon request; and

Transfer of data via electronic file will be handled via secure email with appropriate safeguards to ensure patient confidentiality.

SJOA may retain patient records which may reasonably be of value to a patient for a time frame beyond the timeframe stated above. Medical and financial considerations are the primary basis for deciding how long to retain medical records.

D. Destruction of medical records

Destruction of medical records must be such that confidentiality is maintained. Records must be destroyed by shredding, incinerating (where permitted) or by other method of permanent destruction, including purging of medical records from a computer hard drive, server hard drive or other computer media disk.

E. Documentation

As part of the record disposal process, a destruction log must be kept of all charts destroyed, including:

1. Date of destruction
2. Methods of destruction
3. Description of the disposed records (e.g., name, date of birth, social security number, etc.)
4. A statement that the records were destroyed in the normal course of business; and
5. The signature of the individuals supervising and witnessing the destruction.

F. Billing Records

Medical records include financial information, such as billing and insurance data. Billing records should be retained for seven (7) years according to Internal Revenue Service standards. Appointment books may be kept for one (1) year.

San Juan Oncology Associates must provide patients with a written copy of this ploy when registering as a new patient.

Documentation: N. M. Reg. 16.27.18.17, **N.M. Admin. Code 16.10.17.10**