E-Prescribing Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in a ePrescribe program. These include:

- Formulary and benefit transactions—Gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions—Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification—Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent from you are agreeing that Illinois CancerCare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above I hereby provide informed consent to Illinois CancerCare to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Date_____

Print patient name_____D OB_____

Signature of patient or
Guardian_____

Relationship to patient
_____

Financial Agreement

Assignment of Interest and Financial Agreement

The undersigned hereby irrevocable assign to Illinois CancerCare any and all rights which the undersigned and Patient have against any insurance company or other third party payor for payment of the Patient's bill to Illinois CancerCare. The undersigned authorize the application of any overpayment to any unpaid bill at Illinois CancerCare for which the Patient is responsible that has not been paid in full at the time of the overpayment.

The undersigned further agrees that if this account becomes delinquent they will themselves pay all costs of collecting the same including court costs, reasonable attorney fees and/or collection agency commissions or charges. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

I, the undersigned, as patient or as the duly authorized agent of the patient, certify that I have read the above and accept its terms.

Additional Information needed from Medicare Patients only:

Enrollee Name:_____ Medicare Number: _____

The undersigned, requests that payment of authorized Medicare benefits be made either to me or on my behalf to Illinois CancerCare for any services furnished to me by Illinois CancerCare. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient: _____
(Please print full name)

Signature: _____ Date:_____

Date of Birth: _____ SS#: _____

If signed by an authorized representative of the patient, please indicate relationship to patient (e.g. spouse):

Relationship: _____ Witnessed by:_____

This authorization shall be in force until revoked by me in writing or a new one is signed, a photocopy of this authorization shall be as valid as the original.

512-003

Release of Medical Records

Authorization for Release of Medical Records

I,_____ , authorize all entities that share in my medical treatment to furnish Illinois CancerCare with all personal health information and medical records, including those related to mental health, developmental disability, substance abuse, HIV/AIDS, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I also authorize Illinois CancerCare to release any personal health information and medical records about me to other health care providers, insurance companies, or other third party payors necessary for Illinois CancerCare to provide treatment, payment, or health care operations related to my care, including those records related to mental health, developmental disability, substance abuse, HIV/AIDs, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I understand that this authorization shall be in force until revoked by me in writing or a new one signed. A photocopy of this authorization shall be as valid as the original. I understand that to revoke this authorization I must provide written notice to Illinois CancerCare, Attention Chief Privacy Officer at 8940 N Wood Sage Rd, Peoria, IL 61615.

Date of Birth:_____ SS#:_____

Signature: _____ Date: _____

If signed by an authorized representative of the patient, please indicate relationship to patient (e.g. spouse):

Relationship: _____ Witnessed by:_____

512-002

ILLINOIS CANCERCARE, P.C.

Specializing in Cancer and Blood Disorders

PATIENT REGISTRATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: _____

PATIENT INFORMATION

Patient's Name Last:	*First:*	*Middle:*

Maiden Name:	*Date of Birth:*	*Age:*

Social Security Number:	*Gender:* ❑ M ❑ F	*Marital Status:* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

ETHNICITY AND RACE

This information helps aid your physician in diagnosis and research of your condition.

Preferred Language:
❑ English ❑ Spanish ❑ Decline to answer ❑ Other _____

Ethnicity:
❑ Hispanic ❑ Non-Hispanic ❑ Decline to answer

Race: *(Please mark all that apply)*
❑ White ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Hispanic or Latino ❑ Native Hawaiian or Other Pacific Islander
❑ Decline to answer

PREFERRED CONTACT NUMBER

❑ Home _____ ❑ Work _____ ❑ Mobile_____

PHYSICIAN INFORMATION

Family Physician:	*Referring Physician/Other Physician:*
1.	*1.*
2.	*2.*
3.	*3.*

PATIENT DEMOGRAPHICS

Home Street Address:	*City:*	*State:*	*Zip Code:*

Home Phone #:	*Mobile Phone #:*	*Email:*

Occupation:	*Employer:*	*Employer's Phone # :*

Employer's Address:

Retired: ❑ Yes ❑ No	*If yes, retired from:*

SPOUSE'S INFORMATION

Spouse's Name Last:	*First:*	*Middle:*
Date of Birth:	*Social Security Number:*	
Occupation:	*Employer:*	*Employer's Phone #:*
Employer's Address:		
Retired: ❑ Yes ❑ No	*If yes, retired from:*	

EMERGENCY CONTACT INFORMATION

First Name:	*Last Name:*	*Relationship:*	*Home Phone #:*	*Mobile Phone #:*
1.				
2.				
3.				

INSURANCE INFORMATION

Primary Insurance

Name:	*Address:*	*Phone #:*
Referral Required: ❑ Yes ❑ No	*Prescription Card:* ❑ Yes ❑ No	
Policy Holder Name:	*Patient's Name:*	
Policy Number:	*Group #:*	*Approved Hospital:*
Co-Pay Amount:	*Relationship to Policy Holder:*	*Phone #:*

Secondary Insurance

Name:	*Address:*	*Phone #:*
Referral Required: ❑ Yes ❑ No	*Prescription Card:* ❑ Yes ❑ No	
Policy Holder Name:	*Patient's Name:*	
Policy Number:	*Group #:*	*Approved Hospital:*
Co-Pay Amount:	*Relationship to Policy Holder:*	*Phone #:*

MEDICAL HISTORY

Please write down the reason why you came to the doctor this time:

Normal Weight:	*Present Weight:*		
Weight Loss Amount:	*Duration of Loss:*	*Weight Gain Amount:*	*Duration of Gain:*

SURGERIES

Year:	*Surgery Performed:*	*Hospital:*
1.		
2.		
3.		
4.		
5.		
6.		

Have you ever had a blood transfusion? ❑ Yes ❑ No

If so, have you ever had a reaction? *(If yes, please explain.)*

PAST ILLNESSES

Have you ever had any of the following:

❑ Hearing Loss
❑ Visual Loss
❑ Glaucoma
❑ Migraine Headaches
❑ Epilepsy
❑ Stroke or Paralysis *(explain below)*
❑ Thyroid Disease
❑ Hearing Loss
❑ Arthritis or Rheumatism
❑ Liver Disease/Hepatitis/Jaundice
❑ Other/Explanations:

❑ High/Low Blood Pressure
❑ Heart Disease *(explain below)*
❑ Conjestive Heart Failure
❑ Rheumatic Failure
❑ Pneumonia
❑ Tuberculosis
❑ Asthma
❑ High/Low Blood Pressure
❑ Gallbladder Disease

❑ Stomach Disease/Ulcer *(explain below)*
❑ Kidney Disease
❑ Nervous/Mood Disorder *(receiving counseling?)*
❑ Bleeding Disorder
❑ Clotting Disorder
❑ Chronic Infections *(explain below)*
❑ Prior Cancer *(explain below)*
❑ Stomach Disease/Ulcer *(explain below)*
❑ Diabetes (❑ Type 1 or ❑ Type 2)

_____

_____

_____

MEDICINES

If you brought a list of medications with you, you don't have to fill this out.

Name of Drug:	*Strength/Dosage:*	*Frequency Taken:*

ALLERGIES TO MEDICATION

Name of Drug:	*Reaction you had:*
1.	
2.	
3.	
4.	

Are you allergic to Iodine (IVP Dye, Arteriogram Dye, Shell Fish)? ❑ Yes ❑ No

If yes, please explain:

SOCIAL HISTORY

All questions on this questionnaire will be kept strictly confidential.

Diet	*Are you on a special kind of diet?* ❑ Yes ❑ No Explain: _____		
Caffeine	❑ None ❑ Coffee ❑ Tea ❑ Cola		
Alcohol	*Do you drink alcohol?* ❑ Yes ❑ No	*Did you drink in the past?* ❑ Yes ❑ No	
Tobacco	*Do you use tobacco?* ❑ Yes ❑ No	*How many years?* _____	*Year that you quit?*_____
Drugs	*Do you currently use recreational or street drugs?* ❑ Yes ❑ No		

FAMILY HISTORY

Has any blood relative ever had any of the following:

❑ Anemia	❑ Cancer	❑ Diabetes	❑ Inherited Kidney Disease
❑ Bleeding Problems	❑ High Blood Pressure	❑ Stroke	❑ Mood Disorder
❑ Blood Clots	❑ Heart Disease	❑ Tuberculosis	❑ Other

Please explain: _____

_____

_____

If Living Age/Health	**If Deceased** Age/Cause of Death	**If Living** Age/Health	**If Deceased** Age/Cause of Death
Father:		Spouse:	
Mother:		Son/Daughter:	
Brother/Sister:			

FEMALES ONLY

Date of Last Period:	❑ Regular ❑ Irregular
Number of Pregnancies? _____	*Number of Miscarriages?* _____
Prior/current use of oral contraceptives?	
Prior/current use of hormones?	

ADDITIONAL INFORMATION

Please provide any additional information that you feel would be helpful to the doctor:

_____

_____

_____

_____

_____

_____

ILLINOIS CANCERCARE SOCIAL SERVICES

HULT CENTER FOR HEALTHY LIVING

AMERICAN CANCER SOCIETY

Illinois CancerCare is proud to partner with the Hult Center for Healthy Living and the American Cancer Society (ACS) to provide the following services to our patients and families.

Name: _____

Address: _____ City/State/Zip: _____

Type of cancer: _____ Doctor: _____

Date of birth: _____ Today's date: _____ Phone:_____

I would like more information about the following services:

- ☐ Help for children coping with a parent who has cancer (Kids Konnected/Hult)
- ☐ Support Groups (Hult)
- ☐ Individual counseling for the patient, family members, or caregivers (Hult)
- ☐ Massage therapy for patients in treatments ($30 fee/hr) (Hult)
- ☐ Massage therapy for caregivers of patients in treatments ($35 fee/hr) (Hult)
- ☐ Healthy Living classes (yoga, exercise classes, Tai Ji, meditation) (Hult)
- ☐ Nutritional counseling (Hult)
- ☐ Meal resources/home delivered meal programs (fee may be required) (ACS)
- ☐ Homemaker services, cleaning, errands, general assistance (per service fees apply) (ACS)
- ☐ Financial assistance for treatment, medications, or medical supplies (ACS)
- ☐ Transportation assistance for appointments (ACS)
- ☐ Lifeline® Home Emergency Response System (monthly service fee) (ACS)
- ☐ Wigs, hats, turban resources (ACS)
- ☐ Look Good Feel Better® (ACS)
- ☐ Housing/lodging information (ACS)
- ☐ Living will/power of attorney directives (ACS)

All services are free unless otherwise noted.

FOR MORE DETAILED INFORMATION ABOUT THESE SERVICES, SEE THE SOCIAL SERVICES SECTION OF BINDER

Depending on what services you have checked, you may either receive a phone call, e-mail, or U.S. mail from the American Cancer Society or Hult Center for Healthy Living regarding these services

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Would you like more information about or receive any of the following publications?

- ☐ Clinical Cancer Research Trials
- ☐ The Hult Center for Healthy Living newsletter
  - o By e-mail: _____
- ☐ Illinois CancerCare newsletter by e-mail: _____
- ☐ No, not at this time