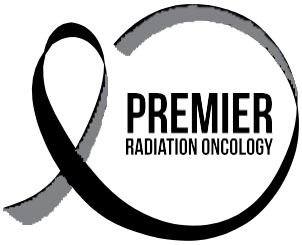
601 S. Armenia Avenue
Tampa, FL 33609
P 813-353-8803 ● F 813-353-8602

Alexander Engelman, M.D.



3140 S Falkenburg Rd., Suite 104
Riverview, FL 33578
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PATIENT PERSONAL INFORMATION

Please Print Legibly

Name (Full legal): _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Sex: ❑ Male ❑ Female Birth Date: _____/_____/ _____

Home Phone: (_____)_____–_____ Cell Phone: (_____)_____–_____

Email Address (use BLOCK letters): _____

Soc. Sec. #: _____–_____–_____ Occupation: _____

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Separated ❑ Widowed

Race: ❑ Caucasian ❑ Black ❑ American Indian ❑ Asian ❑ Hispanic ❑ Other

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____–_____ Ext: _____ Can we call you at work? ❑ Yes ❑ No

Emergency Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Relation: _____ Home Phone (_____)_____–_____

Work Phone: (_____)_____–_____ Cell Phone: (_____)_____–_____

CANCER CENTER OF SOUTH TAMPA
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3140 S Falkenburg Rd., Suite 104
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Current Medical Problem:

Diagnosis: _____

Referred by Dr.: _____

Surgery Done: ❑ Yes ❑ No Dr. _____

Chemotherapy Dates: _____ Dr. _____

Hormone Therapy Dates: _____ Dr. _____

Other Treatment(s): _____ Dr. _____

Current Symptoms or Difficulties (Today): _____

_____

Recent X-Ray – CT Scan – MRI – PET/CT Scan – Bone Scan – Other

Date: _____ @ _____

Date: _____ @ _____

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Please Print Legibly

Primary Care Physician: Name: _____

Address: _____

Phone: _____

Referring Physician: Name: _____

Address: _____

Phone: _____

Do You: Smoke? _____ Packs Per Day _____ Years Smoked _____ When Did You Quit: _____

Drink Alcohol? _____ Drinks Per Week # _____

Drink Cola / Coffee? _____ How much per day? _____

List the Medications You Are Now Taking:

_____

_____

_____

List Any Allergies You Have to Drugs, Food, or Other Items:

_____

List All Operations:

Operations Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List All Stays in the Hospital (Except for Childbirth):

Reason Hospitalized	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List All Medical Problems You Have / Had and Dates:

_____

_____

Last Colonoscopy. Chest X-Ray? _____

Please List All Family Medical History Including Cancer:

_____

_____

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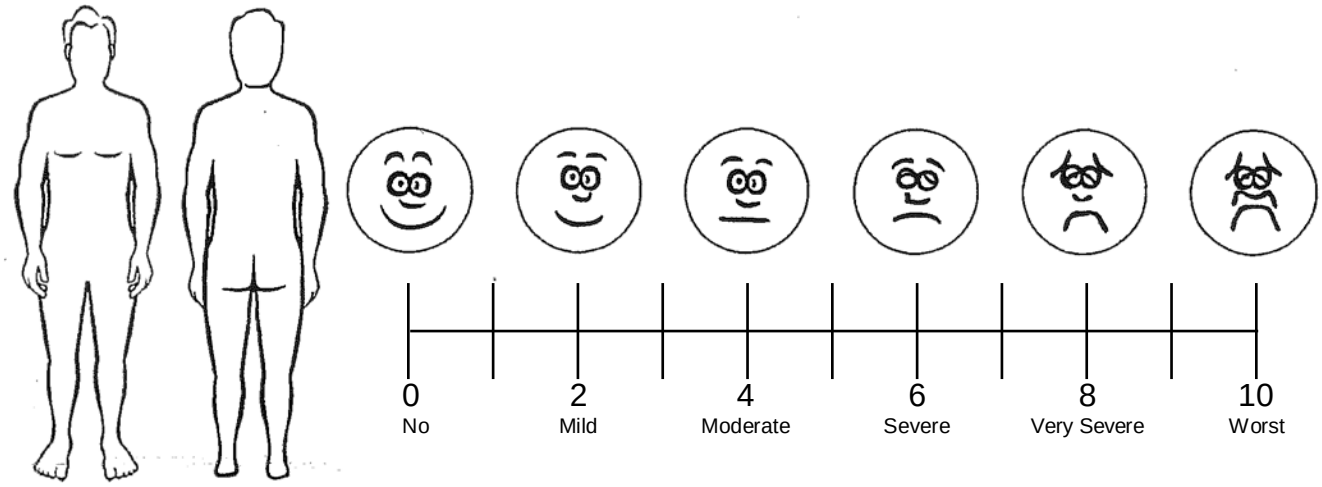
MEDICAL HISTORY FORM

DO YOU HAVE ANY PAIN?
PLEASE MARK ON THE PICTURE WHERE THE PAIN IS LOCATED AND HOW BAD



ADDITIONAL INFORMATION:
FOR WOMEN:

AGE AT FIRST MENSES		AGE AT LAST MENSES	
NUMBER OF PREGNANCIES		NUMBER OF LIVE BIRTHS	

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR BREAST?

NIPPLE DISCHARGE_____ TENDERNESS _____ MASSES_____ FIBROBLASTIC DISEASE_____

DATE OF LAST MAMMOGRAM_____DO YOU DO BREAST SELF EXAMS? YES_____NO _____

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Print Name of Witness: _____

Signature of Witness: _____

Date: _____

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○Y Ⓝ

Allergic/Immunologic

- ○ ○ Frequent Colds
- ○ ○ HIV Risk Factors
- ○ ○ Seasonal Allergies/Hay Fever
- ○ ○ Hx. of Organ Transplant
- ○ ○ Taking Chemotherapy in Last 3-6 Mo
- ○ ○ Year-round Allergies
- ○ ○ Other - Please Explain

Constitutional

- ○ ○ Chills
- ○ ○ Fatigue
- ○ ○ Fever
- ○ ○ Night Sweats
- ○ ○ Weight Gain (Unintentional)
- ○ ○ Weight Loss (Unintentional)
- ○ ○ Other - Please Explain

Ears, Nose & Throat

- ○ ○ Ear Pain
- ○ ○ Hearing Problems
- ○ ○ Nasal Congestion
- ○ ○ Non-healing Nasal Ulcer
- ○ ○ Runny Nose (Frequent)
- ○ ○ Sore Throat
- ○ ○ Tooth Pain
- ○ ○ Hoarseness
- ○ ○ Dentures
- ○ ○ Dry Mouth/Metallic Taste
- ○ ○ Chronic Sore Tongue
- ○ ○ Difficulty Swallowing
- ○ ○ Severe Hearing Loss
- ○ ○ Other - Please Explain

Endocrine

- ○ ○ Hair Loss
- ○ ○ Heat/Cold Intolerance
- ○ ○ Excessive Body Hair Growth
- ○ ○ Infertility
- ○ ○ Excessive Thirst
- ○ ○ Excessive Hunger
- ○ ○ Excessive Sweating
- ○ ○ Other - Please Explain

Eyes

- ○ ○ Blurred Vision
- ○ ○ Eye Pain
- ○ ○ Glasses/Contacts
- ○ ○ Eye Drainage

Ⓨ Ⓝ

Heart and Circulation

- ○ ○ Chest Pain
- ○ ○ Dizziness
- ○ ○ Palpitations/Irregular Heart Beat
- ○ ○ Ankle and Leg Swelling
- ○ ○ Varicose Veins
- ○ ○ Swelling of Feet/Ankles
- ○ ○ Episodes of Fast Heart Rate
- ○ ○ Any Heart Defect

Lungs and Breathing

- ○ ○ Cough (Chronic)
- ○ ○ Shortness of Breath
- ○ ○ Exposure to TB
- ○ ○ Coughing Up Blood
- ○ ○ Wheezing
- ○ ○ Other - Please Explain

Gastrointestinal

- ○ ○ Abdominal Pain
- ○ ○ Acid Reflex/Heartburn
- ○ ○ Loss of Appetite
- ○ ○ Nausea
- ○ ○ Vomiting
- ○ ○ Bloating
- ○ ○ Pain with Swallowing
- ○ ○ Constipation
- ○ ○ Diarrhea
- ○ ○ Hemorrhoids
- ○ ○ Tarry or Clay Colored Stool
- ○ ○ Other - Please Explain

Genitourinary

- ○ ○ Painful Urination
- ○ ○ Blood in Urine
- ○ ○ Frequent Urinary Tract Infections
- ○ ○ Up at Night to Urinate
- ○ ○ Urinary Incontinence
- ○ ○ Urine Stream Change
- ○ ○ Flank Pain
- ○ ○ Genital Lesions
- ○ ○ Unprotected Intercourse
- ○ ○ Impotence/Problems with Erections (Male)
- ○ ○ Other - Please Explain

Ⓨ Ⓝ

Musculoskeletal

- ○ ○ Back Pain
- ○ ○ Joint Aches
- ○ ○ Joint Pain
- ○ ○ Joint Stiffness
- ○ ○ Muscle Pain
- ○ ○ Muscle Aches
- ○ ○ Muscle Stiffness
- ○ ○ Problems Walking

Neurological

- ○ ○ Dizziness
- ○ ○ Fainting
- ○ ○ Headaches
- ○ ○ Memory Loss
- ○ ○ Seizures
- ○ ○ Vertigo
- ○ ○ Stroke
- ○ ○ Paralysis
- ○ ○ Speech Change
- ○ ○ Limited Motion
- ○ ○ Other - Please Explain

Psychiatric

- ○ ○ Anxiety
- ○ ○ Depression
- ○ ○ Feeling Stressed
- ○ ○ Personality Change
- ○ ○ Recreational Drug Use
- ○ ○ Sleep Disturbance
- ○ ○ Suicidal Thoughts
- ○ ○ Other - Please Explain

Skin /Breasts

- ○ ○ Acne
- ○ ○ Mole(s) That Concern You
- ○ ○ Yellowing of Skin or Eyes
- ○ ○ Excessive Itching
- ○ ○ Rashes
- ○ ○ Wart(s)
- ○ ○ Breast Tissue Sensitivity
- ○ ○ Breast Tissue Changes
- ○ ○ Breast Mass
- ○ ○ Self Breast Exams (Female)
- ○ ○ Other - Please Explain

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____

to furnish the following medical information and records: (check all that apply):

☐ The patient's medical records and/or imaging studies and reports, including:

Outpatient Referral **Discharge Summary** **Clinical History**

Radiology Studies X-Ray, CT, MRI, etc… **Recent Laboratory Reports** **Pathology Reports**

Operative Reports

☐ Medical Information as related to: _____

☐ Records dated: _____ ❑ Other: _____

for the purpose of: _____

Records to be sent to:

Premier Radiation Oncology
3140 S Falkenburg Road
Suite 104
Riverview, FL 33578
Phone: 813-734-8911
Fax: 813-734-8920

Cancer Center of South Tampa
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Fax: 813-353-8602

In addition to the information listed above, I authorize the release of the following (Initial if appropriate):

☐ Diagnoses and/or treatment for alcohol and/or drug abuse _____

☐ Psychiatric or psychotherapeutic records _____

☐ Sexually transmissible disease and HIV test results _____

My refusal to sign this authorization will not affect my ability to obtain treatment or payment. This authorization will remain in effect until: _____

I understand that the information released may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the practice has already taken action in reliance on my authorization. _____

_____ _____
Print Name of Patient

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Legal Representative (Print Name) Relationship to Patient

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CONSENT FOR PATIENT PHOTOGRAPHY

(MEDICAL CARE DOCUMENTATION)

I understand that photographs may be recorded of my treatment site(s) for medical care documentation; and I consent to this. I understand that Cancer Center of South Tampa / Premier Radiation Oncology will retain the ownership rights to these photographs and that they will be filed as a permanent part of my medical record for the time period required by law or outlined in Cancer Center of South Tampa's / Premier Radiation Oncology Premier Radiation Oncology's policy. Images that identify me will be released only upon written authorization from me or my legal representative.

_____
Print Name of Patient or Legal Representative

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

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Cancer Center of South Tampa / Premier Radiation Oncology
Alexander Engelman, M.D.

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.
This office uses and discloses your protected healthcare information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered
- To determine a patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- Occasional photographs and other letters and cards of appreciation from patients that are displayed.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: **Russ Williams,** and can be reached at **727-667-2924.**
- Inspect copy and amend your protected health information and amend it as allowed by law.
- To render a complaint to our privacy officer or the secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (Print) _____

Signature of Patient / Legal Representative _____

Date _____

Alexander Engelman, M.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Information:

Name:_____ Date of Birth: _____

Last 4 digits of Social Security #_____

I authorize and request Cancer Center of South Tampa / Premier Radiation Oncology to receive copies of medical records from any Physician's Office, Laboratory and/or Hospital that has any health information on me. The information that is being requested is needed as soon as possible in order to get the proper medical treatment I need at the time services are rendered,

Medical Records are being requested at this time from

_____

_____

_____

Patient's Name (Print) _____

Signature of Parent/Legal Guardian _____

Date_____

Medical records need to be faxed to: (circle one).

If access to fax information is not available, please mail medical records to:

Cancer Center of South Tampa
601 S. Armenia Ave,
Tampa, FL 33609
Phone: 813-353-8803
Fax: 813-353-8602

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Persons Authorized to Receive Information:

Health Information Cancer Center of South Tampa / Premier Radiation Oncology collects or receives about you may be disclosed to the following persons:

_____
Name of Person / Relation / Organization

_____
Name of Person / Relation / Organization

_____
Name of Person / Relation / Organization

Use and disclosure of information:

____ I authorize the person / organization for the above to receive <u>all health information</u> about appointments, treatments and/or other information pertinent to my health care and/or payments for my health care provided at the office of Alexander Engelman, MD.

——I do not authorize the following information to be disclosed to any other parties except to me, as the patient:

_____

_____

_____

_____

_____

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ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ (_____) _____
Last First M.I. Home Telephone

Home Address: _____ **Mailing Address:** _____
Street Street

_____ _____
City State Zip City State Zip

DOB: _____ **Age:** _____ ❑ **M** ❑ **F** **SS#** _____ ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Widowed** ❑ **Other**
Sex *Check Marital Status*

Employer: _____ (_____) _____
Name Telephone

_____
Address Occupation

Responsible Party: _____ (_____) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ (_____) _____
Name Relationship Telephone

Referring Physician: _____ **Primary Care Physician:** _____

Primary Ins: _____ **Telephone (_____)** _____

Insured Name: _____ **DOB:** _____ **Group #:** _____ **Policy #:** _____

Secondary Ins: _____ **Telephone (_____)** _____

Insured Name: _____ **DOB:** _____ **Group #:** _____ **Policy #:** _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Cancer Center of South Tampa / Premier Radiation Oncology. I also authorize agents of any hospital, treatment center or previous physician to furnish Cancer Center of South Tampa / Premier Radiation Oncology copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Cancer Center of South Tampa / Premier Radiation Oncology.
3. My right to payment for all pharmaceuticals, procedures, test, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Cancer Center of South Tampa / Premier Radiation Oncology. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding agreement to collect my benefits as payment for claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Cancer Center of South Tampa / Premier Radiation Oncology.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute, and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with Premier Radiation Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

_____ _____
Patient Signature Date/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (circle one)

EMPLOYEE INITIALS
_____

PHYSICIAN: _____

ACCT. NBR: _____ **LOC:** _____

FOR OFFICE USE ONLY

CONFIDENTIAL
1 – MEDICAL RECORDS 2 – BUSINESS OFFICE/MEDICAL RECORDS 3 – PATIENT

CANCER CENTER OF SOUTH TAMPA
PREMIER RADIATION ONCOLOGY

Courtesy Insurance Billing Service Authorization

With this service, we are able to bill your insurance company directly and save you the paperwork. We need the following authorization from you in order for this to work correctly:

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, AND I HEREBY AGREE TO PAY AS SPECIFIED BELOW.

We will submit your claims for services provided by Cancer Center of South Tampa / Premier Radiation Oncology to your insurance company.

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION

1. **We expect full payment from your insurance company within forty-five (45) days of date of service. If your insurance company has not paid by then, you will be sent a bill and need to make payment within thirty (30) days. Your account balance remains your responsibility.**
2. **Under our Courtesy Billing Program,** we have asked your insurance company to pay us directly, however, some insurance companies may pay the patient instead. If this occurs, you should sign the check over to Cancer Center of South Tampa / Premier Radiation Oncology, mail it with the insurance explanation of benefits and the stub from your monthly statement.
3. You must notify us **IMMEDIATELY** of any changes in your insurance coverage or address/ telephone number.
4. Account balances not paid after sixty (60) days may be subject to a 1.5% per month late payment charge. This charge will be billed to you, not to your insurance company.

I have read the above Courtesy Insurance Billing Program, and understand all aspects of the program. I understand that I will be responsible for any amount not paid by my insurance within 45 days.

_____ _____

Patient Signature **Date**

_____ _____

Guarantor's/Spouse Signature **Date**

Alexander Engelman, M.D.

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OFFICE VISITS		LAB / DIAGNOSTIC		DRUGS		ADMINISTRATION	
NEW PT LEVEL 1	99201	LARYNGOSCOPY FIBEROPTIC	31575	LUPRON X3	J9217	SUB Q/ IM INJECT	96372
NEW PT LEVEL 2	99202	TRANSRECTAL ULTRASOUND	76873	ZOLODEX 10.8 MG	J9202	IV PUSH	90784
NEW PT LEVEL 3	99203	TISSUE MARKERS X 2	A4648	ETHYOL 500 MG	J0207	VENIPUNCTU RF	36415
NEW PT LEVEL 4	99204	PLACE INT.D EV	55876	GENTAMYCIN < 80	J1580	SPACE-OAR	55874
NEW PT LEVEL 5	99205	UIS FOR GUIDE & PLACEMENT	76942	PROCRIT PER 1000 UNITS	QU136		
NO CHARGE	99499			ANZEMET 10 MG	J1260		
F/U LEVEL 1	99211			AREDIA 30 MG	J2430		
F/U LEVEL 2	99212			B12 INJECTION	I3420		
F/U LEVEL 3	99213						
F/U LEVEL 4	99214			XOFIGO PLANNING & DRUG ORDERING	77263	ULTRASOUND	76872
F/U LEVEL 5	99215			XOFIGO ADMINISTERING	79101	TBC SCREENING	DQ514P
PROLONGED ½ HR	99354			RADIUM UNITS -_____ICI	A9006	TBC CESSATION	DQ509P
ADDITIONAL ½ HR	99355					TBC COUNSELING	G0436

ORDERS BEFORE NEXT VISIT:

DATE		NAME	COPAY	BALANCE
DR.	TIME	DOB ACCT #	$	$

PT. ID	M	REASON	DIAGNOSIS	TODAY'S PAYMENT
	F			$

INSURANCE COMPANY	POLICY #	AUTH #
	NEXT APPOINTMENT _____ WEEKS _____ MONTHS	

International Prostate Symptom Score (I-PSS)

Patient Name: _____ **Date of birth:** _____ **Date completed** _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
To S							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Li Urin	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**