



6600 66th Street North
Pinellas Park, FL 33781

Frank L. Franzese, M.D.
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Dear Mr., Mrs., Ms., Dr. _____,

We welcome you to WellSpring Oncology. Thank you for the trust you are placing in us to be your caregivers.

This information packet is designed to introduce you to our physicians, staff, Center and the integrated services we offer. In addition, the packet contains three important forms that we ask you to complete *before your first visit*:

- **Patient History**--This important information will allow your doctor to better understand your medical, family and social history.
- **Assignment of Benefits**
- **Consent Forms**

You will also find your "Patient Rights and Responsibilities" that we encourage you to examine carefully. "Advanced Directives" are also available to you upon request.

We have worked very hard to assemble the finest and most caring medical professionals for your personal care. At any point, should you have questions or concerns, feel free to ask any of us. It will be our privilege to help you.

The relationship patients have with their doctors is deeply personal. You have our promise that we will consult with you prior to any treatment so you can make informed choices. We invite you to include your family in this consultation process as well.

We believe in treating the whole person, not just the disease. There are numerous educational and psychosocial resources we can make available to you. Please ask any questions you might have at any time during your treatment with us at WellSpring. We are open Monday-Friday from 7:00a.m. to 5:00p.m. You may also call our WellSpring concierge for assistance.

Should you have an emergency that is life threatening, please call 911. Your physician can also be reached after office hours by dialing 727-343-0600.

Warmest regards,

Frank L. Franzese, M.D.

Robert J. Miller, M.D.

Zucel Solc, M.D.



AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

SSN#: _____ Telephone #: _____

1. I hereby authorize _____ to disclose to _____ my medical information. This information is to cover the period of _____ and is being disclosed for the purpose of: _____

2. I hereby authorize Dr. _____ and/or his staff to discuss my medical condition and treatment plan with _____
Name of person Relationship to patient
Name of person Relationship to patient

3. Medical information to be disclosed (please check all that apply):
[] Complete copy of medical record [] History & Physical [] Physician Progress notes
[] Lab Reports [] Consultation Reports [] Nurse/Clinical Notes
[] X-Ray Reports [] X-Ray Films
[] Other Diagnostic Reports (please specify) _____

[] Re-disclosure of records from the following facility: _____
(Patient to initial block when asking for re-disclosure)

4. I understand this could include information of a superconfidential nature relating to:
(Patient to check and initial appropriate block)
[] Acquired immune deficiency syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV) documentation and/or testing results.
[] Psychiatric care documentation
[] Alcohol and/or drug abuse documentation

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this information. **Unless otherwise revoked, this authorization will expire 1 year from the date of this signature.**

6. WellSpring Cancer Center, L.L.C., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNED: _____
Patient signature Date

Legal representative and relationship to patient if patient is unable to sign Date

WITNESS: _____
Date

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient's Name: _____ Today's Date: _____
Last First M.I. Home Telephone

Home Address: _____ Mailing Address: _____
Street Street

City State Zip City State Zip

Date of Birth Age Sex Social Security Number

Single Married Divorced Widowed
Marital Status

Email address: _____ (Will only use to inform you of important WellSpring events)

Race: Caucasian _____ Black _____ Asian _____ Hispanic _____ Other _____

Employer: _____ (_____) _____
Name Telephone

Address Occupation

Responsible Party: _____ (_____) _____
Name Relationship Telephone

Emergency Contact: _____ (_____) _____
Name Relationship Telephone

Referring M.D. _____ Primary Care M.D. _____

Primary Ins: _____ Telephone: (_____) _____

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

Secondary Ins: _____ Telephone: (_____) _____

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

- 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).
- I authorize my insurance carrier to release information regarding my coverage to Well Spring Cancer Center, L.L.C. (WSCC).
- My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to WSCC. 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 assignment to collect my benefits as payment of 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 payment to WSCC.
- I understand that I have a right to request and receive a Notice of Privacy Practices from WSCC.

This Agreement/Consent Shall Remain In Effect Unless Revoked By Me In Writing

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

_____ Patient's Signature	_____ Date/Time:	_____ a.m./p.m. Circle one
_____ Responsible Party Signature	_____ Date/Time:	_____ a.m./p.m. Circle one
_____ Witness	_____ Date/Time:	_____ a.m./p.m. Circle one

CONFIDENTIAL



6600 66th Street North Pinellas Park, FL 33781

All of us at WellSpring are pleased to have you as a new patient. Please take a moment to let us know how you heard about us. We thank you for this help and look forward to having you here.

1. How did you hear about us? (check as many as apply)

- Your Doctor's referral
- A friend
- Radio
- TV
- Internet search
- Other _____

2. Where did you get our contact information?

- Doctor gave me your info
- Phonebook
- Radio/TV
- Internet search
- Other _____

3. What other doctors did you consider seeing besides those at WellSpring?

4. Have you seen any of our WellSpring billboards?

YES NO If "Yes" where? _____

5. Have you heard any of our radio ads?

YES NO If "Yes" what radio station? _____

6. Have you seen us on any television programs?

YES NO If "Yes" what station and program? _____

7. From what you've heard, what are we best known for?

- Great doctors
- State of the art technology
- Caring staff
- Beautiful facility
- Other _____

THANK YOU!

Health History Questionnaire

Name: _____ D.O.B.: _____ Date: _____

Referring Physician: _____ Family Physician: _____

Other physicians involved in your care: _____

In order for us to develop a comprehensive treatment plan, we need to clearly and completely understand your current and past medical history. In preparation for your consultation with Dr. _____, please take a moment to provide the following information. Everything disclosed here will be kept **strictly confidential**, but please feel free to leave blank any areas you are unclear on or do not wish to provide.

What is your primary medical reason (diagnosis) that brings you to our office?

Please give a brief history of your current problem (when it started; symptoms; impact on daily living):

Have you received any treatment for your **current** diagnosis of cancer? (Please **list** the type and date of treatment you have received including **prior surgery, chemotherapy, hormone therapy, radiation treatment and/or complimentary/alternative therapies**).

If you have had **prior** cancers (before current illness), please list them and how they were treated:

Allergies: ____ Yes ____ No

List all **Allergies** and describe your reaction:

Medications including vitamins, minerals, herbal and nutritional supplements: (Please **list** and **bring** to appt.)

Medication/Supplement	Dose	Frequency (times per day)	Started	Stopped

Medical History: (Please **check** all current or previous illnesses or conditions.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes/Pre-diabetes | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alzheimers/Dementia |
| <input type="checkbox"/> Environmental/Food Allergies | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Emotional/Mental Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colitis/Chrohn’s | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Bone Disease/Osteoporosis |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems/BPH | <input type="checkbox"/> Other (please list below) |

Health Maintenance: (Please **circle** if you had the test and list date when last performed.)

Colonoscopy _____ Mammogram _____ PSA _____
 Bone Density _____ Pap Smear _____

Other Surgeries and Previous Hospitalizations: (Please **list** what/where and date)

Social History:

What is/was your occupation? _____

Are you retired? _____ Education through grade? _____

Have your been exposed to any chemicals or radiation? _____

Whom do you live with? _____

Do you have children and their ages? _____

Hobbies/Exercise: _____

Spiritual/Religious Practices or Needs: _____

Do you have Transportation/Financial Needs? _____

Tobacco Use (past or present): ____ **Yes** ____ **No** If you indicated **Yes** , list the type of tobacco products you have or currently use and amount per day, the date/age you started and stopped(if applicable):

Exposure to second-hand smoke: ____ **Yes** ____ **No**

Alcohol Use: ____ **Yes** ____ **No** If you indicated **Yes**, list the type and amount of alcohol you currently or previously drank and the date/age you started and/or you quit:

Family History of Cancer: (*Type of cancer, cause of death?*) **None:** _____

Father: _____

Mother: _____

Grandparents: _____

Siblings: _____

Children: _____

Review of Systems: (*Please circle any symptoms you have experienced in the last six months.*)

1. Constitutional:

Appetite loss *Fever* *Weight change* *Night sweats*

Fatigue *Weakness* *Chills*

2. Head:

Hair loss

3. Eyes:

Blurred vision *Excessive tearing* *Double vision* *Visual difficulties*

4. Ear/Nose/Mouth/Throat:

Difficulty swallowing *Pain swallowing* *Oral bleeding* *Phlegm production*

Ringling in ears *Ear pain* *Hearing ability* *Ear infections*

Mouth sores *Nose bleeds* *Mouth dryness* *Sinus infections*

Taste altered

14. Neurologic:

Confusion Dizziness Balance/Difficulty walking Headaches Memory loss
Difficulty sleeping Numbness/Tingling Paralysis Seizures
Sensory problems (changes in sight, smell, taste, hearing)

15. Psychiatric:

Delusions Hallucinations Mood-Depression Mood-Euphoria Mood swings

16. Endocrine:

Diabetes Hot flashes Menstrual irregularities Thyroid disease

17. Hematologic/Lymphatic:

Easy bruising Lymph node swelling Frequent infections

Do you have written Advance Directives? Yes No If yes, could you bring us a copy for our records?

Do you have a living will? Yes No

Do you have a Do Not Resuscitate form on file with your PCP? Yes No If yes, could you bring us a copy for our records?

Have you appointed anyone as Power of Attorney for you? Yes No

If yes, who? _____ Relationship to you _____

Our **mission** at WellSpring is to support both the physical and emotional needs of the patient and family. We understand that receiving a diagnosis of cancer can be frightening and confusing. We invite you to share any additional concerns or feelings. By understanding your needs, we can work together to provide comprehensive and compassionate care and support your return to health.

Patient Signature/Date

Reviewed with Patient by Physician/Nurse and Date