NORTHWEST ONCOLOGY & HEMATOLOGY
Your center of excellence for personalized cancer care

Welcome to Northwest Oncology and Hematology and thank you for choosing us for your care.

BRUCE B. BANK, MD
ELIZABETH J. ELLIOTT, DO
GARY S. GORDON, MD
STEVEN L. KANTER, MD
GARY E. KAY, MD
KEVIN P. MCKIAN, MD
MARINA MESSINGER, MD
ROBERTO MONTOYA, MD
ANITA PANDEY, MD
EDWIN R. PRIEST, MD
RONALD J. SHADE, MD
WAJIHUDDIN SYED, MD
ALKARIM TAJUDDIN, MD
LAI (AMBER) XU, MD, PH.D
EROL YORULMAZOGLU, MD
YIRONG ZHU, DO, PHD

ADVANCED CARE & TREATMENT FOR:
- Lung cancer
- Prostate cancer
- Breast cancer
- Gynecologic cancers
- Colon cancer
- Bladder cancer
- Kidney cancer
- Liver cancer
- Head & neck cancers
- Esophageal cancer
- Leukemia & blood cancer
- Lymphoma
- Sarcoma
- Anemia & blood diseases/di

YOUR COMFORT & CONVENIENCE
- Serene, comfortable environment
- Same-day & next-day appointments
- Early morning appointments
- Infusion therapy
- Most insurance accepted & filed
- Payment plans available
- Oral dispensing service for chemotherapy & supportive drugs

3701 Algonquin Rd., Crossroads Center, Ste. 900
Rolling Meadows, IL 60008
Call: 847.870.4100 • Fax: 847.870.0866

800 Biesterfield Rd., Cancer Institute, Ste. 210
Elk Grove Village, IL 60007
Call: 847.437.3312 • Fax: 847.956.5107

1555 Barrington Rd., Doctors Bldg. 3, Ste. 1200
Hoffman Estates, IL 60169
Call: 847.885.4100 • Fax: 847.885.4199

27750 West Hwy. 22, Ste G70
Barrington, IL 60010
Call: 847.842.0180 • Fax: 847.842.9877

1435 N. Randall Road, Suite 501
Elgin, IL 60123
Call: 847.577.1023 • Fax: 847.717.0166

www.NorthwestOncology.com

To expedite the check in process for your first visit, please complete the attached new patient packet_ The completed forms should be brought with you to your first appointment.

Please arrive at least **20 minutes prior** to your scheduled appointment to complete the registration process.

If you have any questions prior to your first visit, please do not hesitate to contact the New Patient Coordinator at **847.577.0620 x7112**

Visit us on our Website:- NorthwestOncology.com where you will find:

Physicians and Services Information

Locations with maps

You will receive login information for **CareSpace** at your first visit.**CareSpace** is found on our website and gives our patients online access to limited portions of their Northwest Oncology and Hematology patient chart Accessible information includes:

- Certain lab results from blood that is drawn in our office.
- Your current demographic information including your address and phone numbers, insurance information, and other physicians included in your care.
- A summary page that includes current allergies, oncology and hematology diagnoses, and current medication list.
- A calendar showing your scheduled visits.
- A list of recorded vital signs.
- A resource page including educational sites for different diagnoses.

Patient Satisfaction Survey - We value your opinion. After your visit, please complete our ***Patient Satisfaction Survey***, found on our website.

Northwest Oncology & Hematology, S.C.

Financial/Authorization Policy

Our Mission: The physicians, nurses and staff at Northwest Oncology & Hematology strive to provide the highest quality, individualized care for our patients in a compassionate, attentive manner. It is our mission to provide up to date care in an environment that comforts our patients and their families, respects their individual needs and wishes, and preserves their dignity.

We understand this may be a difficult and stressful time for you and your family. Our well-experienced staff will help to answer any questions you have regarding your insurance. Should you require chemotherapy treatment or require imaging services or tests, we will verify your insurance benefits and review the information obtained from your insurance carrier with you. A statement of estimate of financial liability, if any, will be discussed with you at this time.

Please take the time and carefully review how we will partner with you in understanding your financial responsibility, authorization policy and other information you may find helpful. A signature and date is required at the end of this form to serve as acknowledgment and authorization of our policies and procedures described herein.

INSURANCE

Claim Submissions

As a service to our patients, we will file claims to your primary and secondary insurance on your behalf. However, the insurance contracts are between you and your insurance company and you are ultimately responsible to see that your claims are paid in a timely manner.

Insurance Changes

It is your responsibility to notify us immediately regarding any changes in your insurance coverage. This is imperative because most insurance companies have "timely filing" rules, which if missed, will result in denial and non-payment of submitted claims. If this should happen, the full amount billed will become your responsibility to pay. In order to avoid this situation and other similar situations, please contact us as soon as possible with any changes and/or updates to your coverage. If your insurance application is pending with Illinois Department of Public Aid (IDPA) for example, please let us know so we can work with you to expedite the processing of this application.

Medicare – Our physicians are participating providers with Medicare and accept assignment on all covered claims. Medicare requires you to pay the 20% co-insurance and your annual deductible. If you have a secondary (supplemental) insurance, we will file claims to them on your behalf. Medicare reimburses for chemotherapy drugs based on patient diagnosis. If we suspect that Medicare may not cover part of your treatment for your diagnosis, you will be asked to sign an ABN (Advanced Beneficiary Notification) form, which will indicate acknowledgment that you have been informed that part of your treatment may not be covered. We will also work with you to find alternate sources of reimbursement for that part of your treatment that is not covered; for example, the use of a secondary insurance prescription plan or a drug company's patient assistance program.

Financial/Authorization Policy

Medicaid – Our physicians are participating providers with the Illinois Department of Public Aid (IDPA). Claims will be filed on your behalf with a valid IDPA card that shows your eligibility. A valid IDPA card must be presented at the time of service. Services not covered by IDPA, such as spend down amounts, are your responsibility and payment is expected at the time of service.

Managed Care – Our physicians participate in many different plans and although our staff is knowledgeable about many of these, it is ultimately your responsibility to know. Well before you come in for your appointment, please contact your insurance company and verify that your particular plan is one in which we participate. Insurance company websites do not always contain accurate, up-to-date information, so please contact them by telephone instead. Also, please be sure to verify that diagnostic testing will be covered and what facility tests should be directed to (i.e. Quest Labs).

Commercial/Indemnity Plans – Our physicians participate in all of these plans. These plans generally have an annual deductible and an out-of-pocket expense up to a certain dollar amount. These expenses and deductibles are the patient responsibility and are expected at the time of statement.

Co-payments – A co-payment is a fixed amount of money you are required to pay to the provider, facility, pharmacy, etc., when you receive certain services. Co-payments must be paid at the time of service. Your HMO/PPO/POS plan will require that you pay a co-payment when you see your physician, when you have chemotherapy, when you have a port flush, when you have blood drawn, injections, and/or other imaging services/procedures. Please consult your insurance plan for specific coverage information and be prepared to pay this co-payment at the time of service.

Deductibles – A deductible is a fixed amount of expenses you must pay for certain covered services and supplies before your insurance company starts paying benefits for them. Co-payments and coinsurances do not count toward your deductible. If we verify that a deductible or a portion of your deductible has not been met and we verify that your insurance will cover and allow for payment of services rendered, we will ask for the appropriate portion of your deductible to be paid at the time of service. We can make exceptions to this policy if you can provide us with proof from your insurance company that your deductible has been met for the appropriate calendar year.

Coinsurance – A coinsurance is the percentage of your insurance plan allowance that you are responsible to pay for care. Coinsurance amounts are due and payable at time of statement.

Co-payments, Deductibles & Coinsurance – To summarize, co-payments, deductibles and coinsurance represent your contracted portion and financial obligation for services rendered to you. Routine waiver of co-payments, deductibles and coinsurance is considered “misstating the fee for services rendered” and may violate federal, state and local laws and regulations such as the False Claims Act, Anti Kick-back Statues and compliance guidelines for individual and small group physician practices as well as insurance company/participating physician contracts.

Pharmacy Cards – Please inform us if you have a pharmacy card. Certain insurance carriers require certain injectables (drugs) to be obtained from outside sources as opposed to being obtained directly through our office. Therefore, in order to prevent any unnecessary patient financial responsibility, please provide us with this information.

Northwest Oncology & Hematology, S.C.

Financial/Authorization Policy

Referrals – Your Insurance Plan may have specific requirements for referrals to see a physician for diagnostic testing and/or treatments. Please review your particular insurance plan or call your insurance for those requirements. It is your responsibility to ensure that a referral is in place prior to your visit. Patients must present with a valid referral for covered services. Patients will not be seen without the referral. If a patient comes in without a referral, it may be necessary to reschedule the appointment. We will be happy to assist you with obtaining the referral. If the referral is for a series of treatments, which require numerous visits, it is your responsibility to ensure that the referral covers the appropriate number of visits and it is your responsibility to keep track of the number of visits used and the expiration date of the referral. Should you have any questions about this information, please speak with the receptionist at the front desk.

Laboratory – Your insurance plan may have specific rules about where your labs can be drawn. Most plans will only allow a drawing of a CBC (complete blood count) in our office. Some plans only allow CBC draws on days when chemotherapy treatment is also given. Some policies require your labs to be drawn at your PCP (Primary Care Physician) office or at a designated hospital or drawing facility. We hold a contract with Quest Laboratory, which allows us to draw and send out other lab tests; however, the types of tests allowed via this process vary depending on the particular insurance policy. Therefore, please review your policy and obtain accurate information by calling your insurance plan. **We will not be responsible for lab tests processed in an incorrect facility and you will be held accountable for any monies due as a result**.

Hospital Admissions – In the event a hospital stay is needed, please let your physician know which hospital is in your insurance plan network. Your insurance policy will most likely require pre-certification prior to your admission and this information will speed up that process.

Billing and Statements – Any questions concerning your billing statement can be answered by our staff at our Central Billing Office at 847-577-0620, Monday through Friday from 9:00 am – 4:00 pm. Each patient account is assigned and managed by one staff member according to the physician that patient sees. This ensures that you will always speak with the same highly competent specialist regarding your account. This design emphasizes our mission goal, to serve each person individually and to the best of our ability by allowing one particular specialist to familiarize themselves with your account and circumstance. Our staff may need to contact you regarding your account for various reasons; therefore, by signing the acknowledgement of receipt of this Financial/Authorization Policy form, you hereby authorize the staff at Northwest Oncology & Hematology to contact you and/or leave a message on voicemail, answering machine or other electronic device or with a person who answers the phone in regards to your appointments, administrative and/or financial obligations to this practice. You will sign a separate form regarding authorization to contact you and/or others regarding your health and any other health-related issues. We reserve the right to charge an administrative fee to help cover costs incurred in the effort to collect on delinquent accounts and also reserve the right to forward delinquent accounts to an outside collection agency should in-house attempts prove unsuccessful. Therefore, we encourage you to make every effort to keep in touch with us regarding the status of your outstanding account.

Northwest Oncology & Hematology, S.C.

Notice of Privacy Practices

Acknowledgment of Receipt

Patient Name: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Northwest Oncology & Hematology, S.C.

_____ _____

Print Name of Patient or Personal Representative *Signature of Patient or Personal Representative*

_____ _____

Date *Description of Personal Representative's Authority*

Assignment of Benefits

I hereby authorize the release of any medical and other information necessary to insurance companies or associations, employee groups, government agencies or their third party payers and their agents/employees, adjusters and/or attorney's involved in my case, either electronically, by mail, fax or courier, as pertaining to my care in order to process my claims.

I also hereby authorize payment of medical/hospital benefits provided to me and submitted to my insurance company(ies) on my behalf to be paid directly to Northwest Oncology & Hematology, S.C.

If my insurance policy prohibits direct payment to doctor, I hereby instruct and direct my insurance company to do the following for any allowable benefit amounts billed by Northwest Oncology & Hematology and submitted on my behalf: Make the benefit check payable to "my name" and mail it to attention of my name "in care of" to the address as follows:

c/o Northwest Oncology & Hematology, S.C.
3701 Algonquin Road, Suite 900
Rolling Meadows, IL 60008

This is a direct assignment of my rights and benefits under this policy.
A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Print Name of Patient or Personal Representative *Signature of Patient or Personal Representative*

_____ _____

Date *Description of Personal Representative's Authority*

Financial/Authorization Policy Form

Acknowledgment of Receipt

I hereby certify that I have received a copy of the Financial/Authorization Form of Northwest Oncology & Hematology, S.C.
I also hereby certify that I have read and understand the information and policies contained therein and duly authorize Northwest Oncology & Hematology, S.C. to execute the enclosed policies and its terms.

_____ _____

Print Name of Patient or Personal Representative *Signature of Patient or Personal Representative*

_____ _____

Date *Description of Personal Representative's Authority*

Northwest Oncology & Hematology, S.C.#

Patient Name:_____ Date of Birth:_____

We are mandated by the government and the Health Information Technology for Economic and Clinical Health (HITECH) Act to ask certain questions and have the information available in our Electronic Medical Records System (EMR). The HITECH Act provides the Department of Health and Human Services (HHS) with the authority to establish programs to improve healthcare quality, safety and efficiency through the promotion of health information technology (HIT), including electronic health records and private and secure electronic health information exchange. Please fill out the following form and return it to the front desk so your answers can be entered into our EMR system.

Ethnicity *(please circle any that apply)*

Hispanic or Latino

Not Hispanic or Latino

Race *(please circle any that apply)*

American Indian or Alaska Native

Asian

Black or African American

Caucasian

Native Hawaiian or Other Pacific Islander

Other

Preferred Language *(please circle any that apply)*

Chinese

English

French

Italian

Japanese

Korean

Polish

Portuguese

Russian

Spanish

Vietnamese

Preferred Method of Contact *(please circle one)*

Mail

Telephone: Home Work Cell

Northwest Oncology & Hematology, S.C.

Communication Policy and Waiver

Communication is a very important part of providing quality healthcare. In an effort to provide you with information regarding your healthcare, we ask that you complete this waiver. **This form will remain active until a request by the patient is made to have information changed or removed.**

We normally contact our patients between 8:00 am and 5:00 pm. Please provide the phone number that we should use to contact you during this period.

_____ Home Work Cell (please circle one)

If we need to reach you outside these hours, what is the phone number that we should use to contact you?

_____ Home Work Cell (please circle one)

Please list any additional phone numbers we may use to contact you:

_____ Home Work Cell (please circle one)

_____ Home Work Cell (please circle one)

I authorize the following people to receive medical information regarding my care:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize the following person to discuss financial information regarding my account:

Name	Relationship	Contact Number
_____	_____	_____

Do you have voicemail or an answering machine? Yes No (please circle)
May we leave **medical information** on your voicemail or answering machine? Yes No (please circle)

_____
Print Name

_____ _____
Signature *Date*

Recently enacted Federal laws protecting a patient's privacy prevent us from sharing any information about your medical condition without your authorization. If you would like us to release information to anyone other than your physicians that are treating you or your insurance company, please ask to sign a separate authorization.

Northwest Oncology & Hematology, S.C.

Patient History

Name: _____ Date of Birth: _____

Social History

Marital Status: □ Single □ Married □ Domestic partner □ Divorced □ Widowed
Do you have children? □ **Yes** □ **No** If yes, how many children? _____

Occupation (previous, if retired): _____ □ Retire

Do you have an Advance Directive? □ **Yes** □ **No**
Is there a person who you would like to be your primary contact regarding your healthcare? □ **Yes** □ **No**
If yes, Name/Relationship: _____ Phone: _____

Do you currently use tobacco products: □ **Yes** □ **No**
Use per day: □ Cigarettes:_____ □ Cigars: _____ □ Pipe: _____ □ Chewing Tobacco: _____ □ E-Cigs: _____
For how many years have you used the above tobacco product? _____
Have you ever used tobacco products in the past? □ **Yes** □ **No**
If yes, use per day: □ Cigarettes:_____ □ Cigars:_____ □ Pipe:_____ □ Chewing Tobacco:_____ □ E-Cigs:_____
When did you quit? _____ For how many years did you use the above tobacco product? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____
Do you have a history of alcoholism? □ **Yes** □ **No**

Have you used illegal drugs? □ **Yes** □ **No** If yes, which ones? _____
Do you use marijuana? □ **Yes** □ **No**
Are you currently sexually active? □ **Yes** □ **No**
Travel History: Have you traveled outside the US in the past 6 months? □ **Yes** □ **No**
If yes, what countries? _____

Surgical History

Please list all operations and dates of operations:

1	5
2	6
3	7
4	8

Northwest Oncology & Hematology, S.C.

Past and Present Medical Problems

Name: _____ Date of Birth: _____

Check all items either Yes or No and give approximate date if past:

	No	Yes Now	Yes Past	Past Date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (type)				
Arthritis				
Blindness - either eye				
Broken bones				
Cataracts				
Chronic Bronchitis/Lung Disease				
Cirrhosis of liver				
Colon or bowel trouble				
Deafness				
Diabetes Mellitus				
Dysentery				
Ear infections				
Emphysema				
Enlarged heart				
Glaucoma				
Gall stones				
Gout				
Goiter				
Gonorrhea				
Hay fever				
Heart murmur as adult				
Heart attack				
High blood pressure				
Hepatitis				
Hemorrhoids				
Kidney infection				
Kidney stones				
Nervous breakdown				
Poor blood clotting				
Polio				
Phlebitis				
Rheumatic fever				
Rectal trouble				

	No	Yes Now	Yes Past	Past Date
Recurrent boils				
Stroke				
Stomach or Duodenal ulcer				
Syphilis				
Skin Disease				
Serious depression				
Serious emotional problems				
Tuberculosis				
Thyroid (overactive)				
Thyroid (under active)				
Varicose veins				

Men

	No	Yes Now	Yes Past	Past Date
Prostate problems				

Women

	No	Yes Now	Yes Past	Past Date
Menstrual difficulties				
Cystitis				
Mastitis				
Ovarian cyst				
Breast cancer				
Other breast disease				
Still menstruating?				
Age period started:				
Age period stopped:				
Why period stopped:				
Number of pregnancies:				
Number of children:				
Number of miscarriages:				
Explain:				
Date of last mammogram:				

Northwest Oncology & Hematology, S.C.

Current Symptoms

Name: _____ Date of Birth: _____

Symptoms: Please check all that apply or NONE.

Do you have pain? □ **Yes** □ **No**

If yes, where: _____ Intensity (1-10): _____ Frequency: _____

GENERAL: □ ***None***
□ Change in weight
□ Fatigue
□ Change in appetite
□ Night sweats
□ Fever
□ Chills
□ Generalized weakness
□ Frequent colds

EYES: □ ***None***
□ Blurred vision
□ Double vision
□ Change in vision
□ Eye pain

EARS, NOSE, MOUTH and THROAT: □ ***None***
□ Hearing problems / loss
□ Ringing in ears
□ Trouble swallowing
□ Sore throat
□ Nasal drainage
□ Nose bleeds
□ Hoarseness
□ Mouth sores
□ Bleeding gums
□ Dental problems
□ Post nasal drip
□ Sinus trouble

HEART: □ ***None***
□ Chest pain
□ Heart palpitations
□ Light headedness
□ Swollen feet, ankle or hands
□ Murmur

LUNGS: □ ***None***
□ Cough
□ Sputum production
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Difficulty breathing when flat

ENDOCRINE: □ ***None***
□ Hot flashes
□ Frequent urination
□ Excessive thirst
□ Hot & cold intolerance

DIGESTIVE: □ ***None***
□ Nausea
□ Vomiting
□ Heartburn
□ Constipation
□ Diarrhea
□ Abdominal pain
□ Rectal bleeding
□ Bowel incontinence
□ Change in bowel habits
□ Black stools
□ Hemorrhoids
□ Difficulty swallowing
□ Frequent heartburn
□ Belching or excess gas

GENITOURINARY: □ ***None***
□ Burning with urination
□ Pain with urination
□ Blood in the urine
□ Frequent urination
□ Urinary incontinence
□ Excessive urination day/night
□ Slow starting or stopping
□ Unable to hold urine

MEN ONLY…
□ Impotence
□ Prostate infections

WOMEN ONLY…
□ Painful intercourse
□ Vaginal discharge or bleeding

BONES, JOINTS, MUSCLES: □ ***None***
□ Joint swelling
□ Stiffness
□ Back pain
□ Arthritis
□ Muscle Pain □ Bone pain

SKIN: □ ***None***
□ Skin rash
□ Itching
□ Redness
□ Hair loss
□ Nail changes
□ Changes to palms of hands or soles of feet
□ Change in mole or wart
□ A sore that won't heal
□ Other skin complaints

NERVOUS SYSTEM: □ ***None***
□ Headaches
□ Seizures
□ Dizziness
□ Loss of balance
□ Weakness of arms or legs
□ Memory loss
□ Thinking difficulty
□ Numbness in arms or legs
□ Fainting

PSYCHIATRIC: □ ***None***
□ Anxiety/Nervousness
□ Depression
□ Difficulty sleeping/insomnia
□ Work/family stress

BLOOD DISORDERS: □ ***None***
□ Bruising
□ Abnormal bleeding
□ Enlarged lymph nodes

IMMUNOLOGIC: □ ***None***
□ Severe allergic reactions
□ Frequent or severe infections
□ Pollen allergies/hay fever

Northwest Oncology & Hematology, S.C.

Family Health History

Name: _____ Date of Birth: _____

Relative	Age	Currently Living **(L)** or Not Living **(NL)***	*If **NL**, list cause of death	Has/Had Cancer or other Blood Disorders? If yes, list type: *(i.e. breast, lung, colon, clotting issues, leukemia)*
Mother				
Maternal Grandmother				
Maternal Grandfather				
Mother's Siblings				
Father				
Paternal Grandmother				
Paternal Grandfather				
Father's Siblings				
Your Child				
Your Child				
Your Child				
Your Sibling				
Your Sibling				
Your Sibling				
Your Sibling				
Your Nieces/Nephews				
Your Cousins				

Are you of Ashkenazi Jewish descent? □ **Yes** □ **No**

Are you concerned about your personal and/or family history of cancer? □ **Yes** □ **No**

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? □ **Yes** □ **No**

Northwest Oncology & Hematology, S.C.

Medication List

Patient Name: _____ Doctor: _____

Please include regularly taken over the counter drugs, herbs and vitamins.

Date	Drug / Prescription	Dose	Which MD prescribed medication	Date Medication Began

Allergies:

Are you allergic to shellfish and/or the dye used in x-rays? □ **Yes** □ **No**

Are you allergic to latex? □ **Yes** □ **No**

Please list all medications to which you are allergic and the kind of reaction (e.g. hives, breathing problems, rash):

_____

_____

_____