Vita Medical Associates P. C.
Anna Niewiarowska M.D.
306 S New Street Suite 201
Bethlehem, PA 18015
Tel: 610-866-0113 Fax 610-974-8589

Patient Name: _____ Age: _____
(last) (first) (middle)
Birthdate: _____ Sex: Male Female
Address: _____
(Number/Street) (City/State) (Zip Code)
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Spouse Cell: _____
Marital Status: _____ Email: _____
Social Security : _____
Employer Name and Address : _____
Family Doctor: _____
Doctor Name Address/Phone
Referring Doctor: : _____
Doctor Name Address/Phone
Insurance: **Primary**: _____ Effective Date: _____
ID: _____ Group _____
Subscriber: _____
Insurance: **Secondary** _____ Effective Date: _____
ID: _____ Group _____
Subscriber: _____
Spouse Name: _____ Birthdate: _____
Spouse Social Security _____

Date of Onset, Description and Duration of Problem: _____
_____
Pap Tests: Pap Smear, Date: _____ Flexible Sigmoidoscopy, Date: _____
Stool for Hemoccult, Date _____ Mammogram, Date: _____
History of Tobacco Use: _____
Family History of cancer: _____
Family History of Blood Related Problems: _____
Other Medical History: NONE
Hypertension Diabetes Heart Condition Phlebitis/Blood Clots
Other: Explain _____
Medications:
_____
_____
Allergies: _____

Pharmacy Name, Address and Phone Number: _____

I understand that fees for services rendered by Anna Niewiarowska, M.D. are payable to same by myself or my insurance carrier (if assignment of benefits is not accept, I understand I am responsible for the remaining balance, including deductible or co-payments). I authorize Tomasz J Niewiarowski, M.D. to release my insurance company any information necessary to complete claims. I further authorize payment to medical benefits by my insurance company to Anna Niewiarowska, M.D.

Signature: _____ Date: _____

VITA Medical Associates, P.C.

Hematology Oncology

Patient Name: _____

DOB: _____

Date: _____

Brief Patient Symptom Check List

Fever/Chills

_____ Yes If yes, what was your highest temperature at home? _____

_____ No

Nausea/Vomiting

_____ None
_____ Mild
_____ Moderate
_____ Severe

Numbness/Tingling – Location_____

_____ None
_____ Mild
_____ Moderate
_____ Severe

Appetite/Drinking

_____ Normal
_____ Fair
_____ Poor

Sore Mouth/Sore Throat

_____ None
_____ Mild
_____ Moderate
_____ Moderate

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

_____ None
_____ Mild
_____ Moderate
_____ Severe

Please describe location of pain _____

_____ New pain
_____ Chronic pain

Constipation

_____ None
_____ Yes

If yes, when was you last BM? _____

Diarrhea

_____ None
_____ Yes

If yes, how many times a day? _____

Fatigue/Weakness

_____ None
_____ Mild
_____ Moderate
_____ Severe

Shortness of Breath

_____ None
_____ Mild
_____ Moderate
_____ Severe

Emotional Needs

_____ None
_____ Anxious
_____ Depressed

New medications/oral/injectable/supplements_____

_____

Allergies_____

Signature MD/NP/RN/MA _____

Patient/family member signature _____ Date _____

Vita Medical Associates P.C. – Oncology
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Anna Niewiarowska M.D.

AUTHORIZATION

I, _____, authorize Anna Niewiarowska, M.D. to forward medical records regarding my ongoing treatment to the following parties:

Physician	Address	Dates Treated

I understand that I may change this list at any time and I am responsible to keep Dr. Anna Niewiarowska, apprised of any changes to this list. This authorization is to stay in effect until another signed authorization form is issue and signed by me.

Patient or Guardian's Signature: _____ Date: _____

Print Name of Patient: _____

Witness Signature: _____ Date: _____

Print Name of Witness: _____

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgment of notice and consent authorizes VITA Medical Associates, P.C. to use and disclose health information about your for treatment , payment, and healthcare operations purposes.

Notice of Privacy Practices: VITA Medical Associates, P.C. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signed this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to Contact our Privacy Officer

Mail: VITA Medical Associates, P.C.
Attn: Privacy Officer
306 S. New Street Suite 201
Bethlehem, PA 18015
Telephone: 610-866-0113
Fax: 610-974-8589

Acknowledgement and Consent

Print or type all information except signature

I have received the Notice of Privacy Practices for VITA Medical Associates, P.C. and authorize them to use and disclose health information about _____ (patient name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Name of personal representative Relationship to patient

COMMUNICATIONS CONSENT

VITA MEDICAL ASSOCIATES, P C

It is the office policy of VITA Medical Associates, P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell home and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize VITA Medical Associates, P.C. and/or their staff to leave medical information pertaining to my care by the following methods and will assume reasonability to notify them whenever this information changes.

Home Phone:	_____	**yes**	**no**
Answering Machine :	_____	**yes**	**no**
Work Phone (Voicemail) :	_____	**yes**	**no**
Cell Phone:	_____	**yes**	**no**
Email Address:	_____	**yes**	**no**
Send/Receive medical records/Electronic prescription history for referrals to other doctors		**yes**	**no**

If you would like to have information released to someone other than yourself please complete the following:

Please list names and phone numbers of authorized people:

Spouse: _____ Phone: _____
Parent: _____ Phone: _____
Other: _____ Phone: _____
Other: _____ Phone: _____

Printed Name: _____
Signature: _____ **Date:** _____

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Financial Policy

We are committed to providing your with the best possible care. In order to achieve these goals, we need your assistance and your understanding our payment policy.

We are Blue Cross/ Blue Shield and Medicare participating providers as well as participating providers with several other insurance plans/networks. Not all services are a covered benefit by all insurance companies, therefore, any service not covered by your insurance will be your responsibility. If you have any questions regarding your insurance coverage, it is your responsibility to contact your insurance carrier. It is your responsibility to check with your insurance carrier regarding pre-certification and/or second opinion coverage, procedures or clinical studies. Should you need any assistance, our staff will be happy to help you.

Your insurance is a contract between you and the insurance company. If your insurance company requires a referral form, this must be brought at the time of the visit. If it is an electronic referral, it would be greatly appreciated if you would bring the referral number. If you do not bring the referral, we will need to reschedule your appointment or you can pay for the charges on that day. Without referrals, we cannot bill your insurance company and therefore, the patient is billed directly. All office visits, patient responsible, copays are due the day of service.

All charges are your responsibility form the date of service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance. There are many options the billing department can offer such as payment plans, copay foundations, and drug copays cards.

I understand that fees for services rendered by any physician and/or employee of Vita Medical Associates P.C. are payable to same by myself or my insurance carrier(if assignment of benefits is not accepted, I understand I am responsible for the remaining balance, including deductibles, or co-payments, upon receipt of the first billing statement). I authorize Vita Medical Associates P.C. to release to my insurance company any information necessary to complete claims. I further authorize payment of medical benefits by my insurance company to Vita Medical Associates P.C.

Patient or Guardian's Signature: _____ Date: _____

Print Name of Patient: _____

Witness Signature: _____ Date: _____
Print Name of Witness: _____