Lane Hematology/Oncology Clinic

6180 Main Street, Suite A
Zachary, LA 70791
Phone: 225-767-0822 Fax: 225-769-5424

MICHAEL J. CASTINE, M.D.

Thank you for choosing Lane Hematology Oncology Clinic for your medical needs. As the only independent group in the area, we continue to strive to care for our patients with a family atmosphere, using the latest advances, such as Research Trials, and coupling those treatments with compassion.

Since we are not owned by a hospital or any other corporate entity, we have flexibility to provide care in a cost efficient way. We are always in communication with insurers about ways to improve care while controlling costs. As a provider of care, we serve as your advocate to deliver the highest quality of care regardless of the cost as none of us control the cost. But we also try to spend the money as if it were our own in an efficient and cost effective way. In other words, we try to get the most for your healthcare dollar.

With this in mind, certain things can be done to be more cost effective. We have found that dispensing certain medicines through our office is more cost efficient and effective for our patients and our office. You may be approached about this if those medicines are used to in your care.

Also, we have also found that phone calls from patients are best handled as early as possible in the day. We realize that emergencies occur at all hours, and we always have a physician on call to assist with these emergencies. But many times, we may be able to avoid a costly trip to the emergency department or even hospitalization by evaluating patients in our office. And if necessary, we can treat the patient in our chemotherapy room by our experienced staff who already know you and your history.

Therefore, we ask that you call as soon as possible for any distressing symptoms such as fever, nausea, vomiting, diarrhea, and other problems that may be addressed during the day. Our triage nurses have the experience to help direct the best choice of treatment for you during office hours rather than at times when we are forced to rely on Emergency Rooms. We are here to educate you about your health conditions and the side effects of treatment.

We are dedicated to your care and health, and most of our staff has devoted their careers to caring for cancer patients. We are thankful and privileged that you entrust your care to us.

IMPORTANT NUMBERS:

Main Number 225-767-0822 (Use this number for daytime access to the triage nurse and other questions.)

After Hours 225.767.0822 (If there is no answer, you may contact the answering service for assistance 225-387-1918.)

Appointments 225-761-3900 (Use this number to change or schedule routine appointments.)

Please keep your pharmacy number handy when calling after hours in case prescriptions are needed. Be sure the pharmacy has late hours as prescriptions may be needed at night or weekends.

Thank you, Lane Hematology/Oncology Clinic

Lane Hematology/Oncology Clinic
Patient Medical History

Today's Date: _____

Name:_____ Date of Birth:_____Age:_____

Place of Birth:_____ Occupation:_____

Education:_____ Years of High School:_____ Years of College:_____

Reason for Visit: _____

_____

Family History

	Name	If Living, Age	If Deceased, Age at Death	Illnesses
Father:				
Mother:				
Siblings:				
Children:				

_____

_____

_____

_____

Tobacco use: ____ Yes _____ No How many years?_____Pack/s per day? _____ When did you quit?_____

Alcohol use: ____ Yes _____ No How many drinks per: Day _____ Week _____ Month _____

Obstetrical History: _____# of Pregnancies _____## of Live births

Contraception use: Type? _____How long?_____

Hysterectomy: ____ Yes _____ No What year? _____

Ovaries removed: ____ Yes _____ No What year?_____

Hormone replacement therapy: ____ Yes _____ No How long?_____

Are you allergic to any medications or food? ____ Yes _____ No

Please list: _____

Patient Medical History Continued

Name:_____ Date of Birth _____

Current or Past Medical Conditions (check all that apply)

___Heart Disease/Murmur/Angina
___Seizures
___Diabetes
___Liver Problems/Hepatitis
___Neurologic problems
___Anemia or blood problems
___High blood pressure Stroke
___Kidney/Bladder problems
___Lung problems/Asthma
___Headaches
___High cholesterol Blood clots
___Thyroid disease
___Shortness of Breath
___Cancer

Please describe any current or past medical conditions not listed above:

_____

_____

_____

_____

List any past surgeries and date:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any other information you would like the doctor to know:

_____

_____

_____

_____

Signature:_____ Date:_____

Lane Hematology/Oncology Clinic

CONSULT WITH *(CHECK ONE):*

Michael J. Castine, M.D._____
Christopher M. McCanless, M.D. ___
Gerald P. Miletello, M.D____

PATIENT INFORMATION (PLEASE PRINT)

Social Security# _____

Name: Last_____ First _____ M.I. __ Lineage _____

D.O.B.: _____Gender: M___ F __

Home Phone _____ Cell Phone___

Street Address _____ City _____ State___ Zip_____

Driver's License# _____

Email Address: _____

RACE (Check One)

Caucasian _____ Asian _____ Other Pacific Islander _____
Black _____ American Indian _____ Other _____
Hispanic _____ Native Hawaiian _____

Ethnicity: Hispanic or Latino _____ Non-Hispanic or Non-Latino _____

Marital Status: Single _____ Married_____ Divorced_____ Widowed_____ Other_____

Employer:_____Employer Phone_____
Student _____ Retired _____ Unemployed _____

Do you have an advanced care directive or living will? ____ Yes _____ No
Copy provided? ____ Yes _____ No

Communication Preference (Check One)

Home Phone (_____)_____ or Cell Phone (_____)_____

Leave Message? _____Yes _____ No

Name:_____ Date of Birth _____

Responsible Party_____Phone_____

Relation to Patient_____

Primary Care Physician _____Phone _____

Referring Physician_____Phone _____

INSURANCE INFORMATION

Primary Insurance_____Policy#_____Group # _____

Cardholder_____Relationship to cardholder_____

Secondary Insurance_____Policy#_____Group #_____

Cardholder_____Relationship to cardholder_____

SPOUSE INFORMATION (if applicable)

Name_____Work Ph._____Cell Ph._____

Social Security # _____ Date of Birth: _____

AUTHORIZATION/ RESPONSIBILITY
ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare/Private Insurance benefits be made either to me or on my behalf to Hematology/ Oncology Clinic for any services furnished me by that provider.
I authorize any holder of medical information about me to release to the Health Care Financing Administration/Private Insurance and its agents and any information needed to determine these benefits for the benefits payable for related services.

_____ _____

Signature of Patient or Authorized Representative Date

LANE HEMATOLOGY *I* ONCOLOGY CLINIC
A copy can be considered as an original for insurance purposes

I acknowledge and understand that I am responsible for any professional services rendered to me. Although I have requested the doctor to bill my insurance company, I clearly understand that it is my responsibility to make sure my bill is paid in a reasonable amount of time. If for any reason my bill is not paid in full by my insurance, I further agree to make arrangements to settle the unpaid balance on my account.

_____ _____

Signature of Patient or Authorized Representative Date

Lane Hematology/Oncology Clinic

Name:_____ Date of Birth_____

REVIEW OF SYSTEMS

	Y	N	*NIA*
GENERAL			
Appetite Loss	D	D	D
Weight Loss	D	D	D
Weight Gain	D	D	D
Fever	D	D	D
Chills	D	D	D
Fatigue	D	D	D
Hot Flashes	D	D	D
Night Sweats	D	D	D
Pain, Location	D	D	D
SKIN			
Bruising	D	D	D
New Lesions	D	D	D
Dryness	D	D	D
Rash	D	D	D
HEENT			
Headache	D	D	D
Visual Disturbances	D	D	D
Hearing Loss	D	D	D
Nasal Congestion	D	D	D
Seasonal Allergies	D	D	D
Mouth Sores	D	D	D
Sore Throat	D	D	D
Bleeding Gums	D	D	D
Double Vision	D	D	D
Dry Eyes	D	D	D
Nose Bleeds	D	D	D
RESPIRATORY			
SOB (shortness of breath)	D	D	D
Cough	D	D	D
Sputum Production	D	D	D
Coughing Up Blood	D	D	D
CARDIOVASCULAR			
Irregular Heart Rhythm	D	D	D
Chest Pain	D	D	D
Edema	D	D	D
Elevated BP	D	D	D
Palpitations	D	D	D
GASTROINTESTINAL			
Heartburn	D	D	D
Abdominal Pain	D	D	D
Blood in Stools	D	D	D
Constipation	D	D	D
Diarrhea	D	D	D
Difficulty Swallowing	D	D	D
Nausea	D	D	D
Vomiting	D	D	D

GENITOURINARY	Y	N	*NIA*
WOMEN:			
Age of 1st period_____			
Age of 1st Live Birth_____			
Age of Menopause_____			
Blood in Urine	D	D	D
Incontinence	D	D	D
Times Voiding At Night_____			
Menstruation# of Days_____			
Length of Cycle_____			
MEN			
Incontinence	D	D	D
Hesitancy	D	D	D
Void Frequently	D	D	D
Times Voiding at night _____			
Trouble starting stream	D	D	D
MUSCULOSKELETAL			
Back Pain	D	D	D
Bone Pain	D	D	D
Joint Pain	D	D	D
Muscle Stiffness	D	D	D
Muscle Pain	D	D	D
Muscle Cramps	D	D	D
NEUROLOGICAL			
Numbness & Tingling Location _____	D	D	D
Dizziness	D	D	D
Fainting	D	D	D
Unsteadiness	D	D	D
Weakness	D	D	D
PSYCHIATRIC			
Mood Swings	D	D	D
Anxiety	D	D	D
Depression	D	0	D
Inability to Concentrate	D	D	D
Difficulty Sleeping	D	D	D
HEMATOLOGY			
Abnormal Bleeding	D	D	D
History of Blood Clots	D	D	D
Enlarged Lymph Nodes	D	D	D
Easy Bruising	D	D	D
IMMUNOLOGY			
History of:			
Sinus Infection	D	D	D
Bladder Infection	D	D	D
Pneumonia	D	D	D
Bronchitis	D	D	D

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MICHAEL J. CASTINE, M.D.

REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM:

_____

_____

I hereby request that my records be released to:

Lane Hematology/Oncology Clinic

6180 Main Street, Suite A
Zachary, LA 70791

PLEASE PRINT

Patient's Name:_____ D.O.B._____

Address: _____

City:_____ State:_____ Zip:_____

Date:_____ Patient's Signature: _____

Received by: _____

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Release of Personal Health Information

I, _____ **(print name) give**

Lane Hematology/Oncology Clinic authorization to give my personal healthInformation to the following individual(s):

1. _____ Phone#: _____
2. _____ Phone#: _____
3. _____ Phone#: _____
4. _____ Phone#: _____
5. _____ Phone#: _____

_____ _____

Date Patient's Signature

Lane Hematology/Oncology Clinic

New Patient Medication Sheet

Name: _____ Date of Birth: _____

Medication and Food Allergies: _____

Pharmacy: _____ Phone: _____

DATE: _____

Medication	Dose	Frequency (time of day)	Doctor that prescribed this medication for you?
Reviewed by:		Escribed by:	

HIPAA Notice of PrivacyPractices
Lane Hematology/Oncology Clinic, L.L P.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT Y OU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and can relate to your past, present or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information
Your physician, our physician, our office staff and others outside of our office that are involved in your care and treatment may utilize and disclose your protected health information for the purpose of providing health care services to you; to pay your health care bills; to support the operation of the physician's practice; and other use as required by law.

Treatment:
We will utilize and disclose your protected health information in order to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. A second example would be providing your protected health information to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations:
We may utilize or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging business activities. For example, we may disclose your protected health information to medical school students that see patients at or office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, both Public Health and Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security; Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures available to you and when required by the Secretary of the Department of Health and Human Services to in investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of you rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health Care Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of and any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. ***We will not retaliate against you for filing a complaint.***

This notice was published and becomes effective on or before ***April 14, 2003.***

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____ Date:_____

_____Accept Copy _____ Decline Copy