Astera CANCER CARE

NEW PATIENT FORM

Today's Date: _____

(Please print. Thank you.)

Patient Name: _____ MRN#: _____

DOB: ____ / ____ / ____ Age _____ Male Female SSN: _____

Address: _____ Phone: (____) _____

Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ____ Yes ____ No

Email Address: _____ May we email you? ____ Yes ____ No

Preferred Language: _____

Ethnicity/Race: ___ White ___ Hispanic/Latino ___ Black/African American ___ Native American ___ Asian/Pacific Islander ___ Other

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: (____) _____

Power of Attorney (if applicable): _____ Relation to you: _____

Living Will: ____ Yes* ____ No *Please provide a copy for your records

NEW PATIENT FORM

Patient Name: _____

Primary Insurance Carrier

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier

Name of secondary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

How did you learn about Astera?

☐ Physician Referral ☐ Family / Friends ☐ Insurer

☐ Advertisement ☐ Internet Search ☐ Astera Website

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Print Name: _____

REQUEST FOR RELEASE OF RECORDS

I, _____ , request a copy of my complete medical record from the office of:

_____

Name and Address of Practitioner

_____

To be sent to Astera Cancer Care:

_____

Address, City State Zip Code

_____

Fax/Telephone Number

_____ I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

_____

Provide office fax number

It is my understanding that by signing this authorization for release of my records, I am giving permission for Astera Cancer Care to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire 1 year after the date below or sooner at my election.

_____ _____

Print Patient Name Date

_____ _____

Signature Patient, Parent, or Legal Guardian/Representative Date

_____ _____

Witness Date

Astera Cancer Care is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by Astera Cancer Care after April 1, 2021.

USE OR DISCLOSURE AUTHORIZATION FORM

Name of Individual Authorizing Use or Disclosure _____ Telephone Number _____

I hereby authorize the use and/or disclosure of my Protected Health Information by Astera Cancer Care as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health care provider or health plan, the released information may be re-disclosed and may no longer be protected by the federal privacy laws and regulations.

1. The following health information will be disclosed (please check):

- ☐ Cardiac studies
- ☐ Complete record
- ☐ Consultations (including psychiatric evaluations)
- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History & Physical Examination
- ☐ Interdisciplinary Records (Progress Notes)
- ☐ Laboratory Reports (including drug screens)
- ☐ Medication Records
- ☐ Nursing Notes
- ☐ Operative and/or Procedure reports
- ☐ Physician Orders
- ☐ Radiology or Imaging Reports
- ☐ **All of the above**
- ☐ **Other**: (fill below)

_____

_____

2. Person or organization authorized to receive the health information (for example: names of family, caregivers and friends, health insurance, health plan, other providers administering care coordination services):

_____

_____

_____

3. Description of each purpose for which the health information will be used/disclosed (Note: if the individual elects not to provide a reason, insert "At the request of the individual"):

_____

_____

4. I understand that the person or organization that I am authorizing to use or disclose the information may receive compensation in exchange for the health information described above.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits. *

6. I understand that I may revoke this authorization at any time by providing written notice to Astera Cancer Care, J-2 Brier Hill Court, East Brunswick, NJ 08816.

7. I understand that my revocation of this authorization will not affect any actions already taken in reliance on this authorization or certain actions listed in the Astera Cancer Care Notice of Privacy Practices.

8. I understand that I may inspect or copy any information to be used or disclosed under this authorization.

9. Unless otherwise revoked in writing, this authorization will expire _____ days from the date signed below. If this date is left blank, the authorization will automatically expire one (1) year from the date I sign below.

10. Submitted to Astera Cancer Care.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

(*Print*)

Description of Personal Representative's Authority

*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).

Astera CANCER CARE

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Reason for this Visit: _____

_____

_____

_____

_____

Medical History: (Check the items that apply to you, currently or in the past)

- ☐ None
- ☐ Anemia
- ☐ Bleeding Problem
- ☐ Blood Clots
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heartburn / Reflux
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Anxiety / Depression
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia / Bronchitis
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Kidney Disease / Failure
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma

Other Medical History not listed above:

_____

_____

_____

Height: _____ Weight: _____

Have you ever experienced:

- ☐ Weight Loss – how much _____
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Please list all surgeries you have had with approximate date:

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco User:

- ☐ Never Smoked
- ☐ Quit Smoking When did you quit? _____ How many years did you smoke? _____ Yr(s
- ☐ Currently smoke: What age did you start? _____ How many packs? _____ /day

Alcohol User: Present or Past

- ☐ Non-Drinker
- ☐ Drinker _____ Current _____ Past How many drinks per day? _____

Are you: _____ Employed _____ Unemployed _____ Retired _____ Disabled

(Former) Occupation: _____

Marital Status: ___ Married ___ Single Widowed ___ Divorced Domestic Partner

___ Lives alone ___ Lives with family

Children ___ Yes ___ No

Health Maintenance:

Sigmoidoscopy / Colonoscopy:	___ Yes	___ No	Date: _____
Mammogram:	___ Yes	___ No	Date: _____
Bone Density:	___ Yes	___ No	Date: _____
Pap Smear:	___ Yes	___ No	Date: _____
Influenza (Flu) Shot	___ Yes	___ No	Date: _____
Pneumococcal Shot:	___ Yes	___ No	Date: _____

PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Family Medical History: Indicate any family members with cancer, blood disease or other disease

	Age at Diagnosis	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Siblings			
Other			

Drug Allergies (List all medication allergies):

_____

_____

_____

_____

_____

Pharmacy / address / phone#: _____

_____

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency

AGREEMENT TO PAY,
RIGHTS OF EACH PATIENT and
NOTICE of PRIVACY PRACTICES

I acknowledge that I am responsible for payment of the fee for medical services rendered by Astera Cancer Care, regardless of any reimbursement to which I may be entitled by reason of insurance or legal claims. I am aware that it is solely my responsibility to know, in advance of the service, the benefits and guidelines of my individual insurance coverage; to obtain all necessary insurance referral forms and/or pre-certification; and to confirm plan in which Astera Cancer Care, is a participating provider, the payment guidelines of my plan will prevail.

I authorize Astera Cancer Care to prepare and submit the appropriate claim forms to my primary and secondary (if any) insurance carrier (s). I hereby assign all insurance benefits relating to these medical services to Astera Cancer Care and authorize the release of all information necessary to effect payment of those benefits.

Even though payment may be sent directly to Astera Cancer Care, I understand that I am still responsible for any balance remaining and will pay any amount not covered by my insurance. I understand that if I fail to keep any financial agreement, I make with Astera Cancer Care and my account must be sent to a collection agency, I will be responsible for all collections cost and legal fees.

I hereby acknowledge that I have been offered a written copy of the "Rights of Each Patient" adopted by the New Jersey Department of Health for ambulatory care facilities and written or verbal explanation of these rights. I further acknowledge that I understand the explanation given to me about my rights.

I hereby acknowledge that I have been given a offered of the Notice of Privacy Practices from Astera Cancer Care concerning how the use or disclosure of Protected Health Information will be handled by the practice.

I give my consent for Astera Cancer Care to have my report faxed to my physician (s).

_____ _____

Signature Date

Astera
CANCER CARE

BILLING POLICY

Astera Cancer Care participates with most major insurance carriers and will work diligently as your patient financial advocate in an effort to help you understand and access your benefits. Please contact your insurance carrier to confirm that we participate with them and be sure to *bring your insurance cards every time* you come to the office. Also, make sure to inform our staff whenever you have a change of insurance.

For your peace of mind, Astera maintains firm policies and procedures on cost containment and ethical billing practices. Operating in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Astera protects and secures your health information and privacy, ensuring that all of your information will remain confidential.

As a participating provider with your insurance carrier, we are contractually obliged to collect co-pays at the time of service. Your insurance company may require co-pays, not only for office visits with your physician, but also for chemotherapy treatments, injections and laboratory appointments. We must collect co-pays at the time of service for these visits as well. Upon completion of your visit and payment of your co-pay, Astera will bill your insurance company for the remaining balance due. In the event you are unable to pay the co-pay at the time of your visit, we regret we will be unable to accommodate you and your appointment will need to be rescheduled.

If Astera is not a participating provider with your insurance company, we will still forward your billing claims to your insurance company at the time of your visit. Astera will then bill you for any remaining charges not covered by your insurance company. You will be responsible for this remaining balance. In the event we do not participate with your insurance, your treatment may be scheduled at the hospital – it may not be provided in our office.

Patients without any insurance must be prepared to make a full payment at the time of service.

Med-Metrix is responsible for handling patient billing at Astera. Med-Metrix representatives are available Monday thru Friday from 8:00am - 4:00pm to work with you on any questions or concerns you may have and can be reached at 1.800.220.8369.

If your insurance requires referrals, it is your responsibility to ensure the referral is either sent to our office prior to your visit or you may also bring it with you to your appointment. We suggest that you retain a copy so that you may keep track of the number of visits left on your referral and its expiration date. Please feel free to ask Astera to make a copy of your referral for you. We may have to reschedule your visit if you do not have a current referral on file.

If you are unable to make your appointment at Astera, it is important to call us to cancel the appointment a minimum of 24 hours in advance. In the event you do not call us to cancel, we regret we must charge a fee, as we have reserved this time for you.

Astera will bill patients on a monthly basis for the balance of charges not covered by their insurance companies. Astera requests payment of any balance due within sixty days of the date of the Astera bill. After sixty days, balances due will be billed at a rate including an additional 1.5% interest fee per month. Astera accepts payments in the form of cash, check or credit card.

ASTERA CANCER CARE - FREQUENTLY ASKED QUESTIONS

What will occur during my initial visit?
Your physician consultation will generally consist of a physical examination, discussion of medical history and diagnosis, probable plan of care, as well as time for any questions you may have. Initial consultations generally last about an hour to an hour and a half. It is necessary to have your medical records forwarded to our office in advance of your appointment so your Astera Cancer Care physician may review them prior to your visit.

Will I have any testing done while I'm in the office?
Your physician may order some Laboratory testing (blood work) upon the completion of your consultation. This may be completed in our Labs.
Other diagnostic tests, such as scans or x-rays, may be ordered and scheduled for a later date at the appropriate location. These diagnostic tests are not completed in our offices.

Will I start chemotherapy treatment the same day as my consultation?
Chemotherapy treatment will not begin the same day as your consultation. Chemotherapy often requires additional testing such as scans and biopsies before the treatment begins. It is also necessary to have your health insurance company authorize chemotherapy in advance (this generally takes approximately one week) to ensure that your treatment will be covered by insurance. The timing of initial chemotherapy treatments varies on a case by case basis. After your physician has obtained any required test results and your insurance company has authorized the treatment, you will receive a call from the Astera Scheduling Coordinator to schedule your treatment. You will begin with a detailed one-on-one chemotherapy education session with one of our Advanced Practice Providers. This session will provide you with information about your specific treatment and allow you to ask any questions you may have.

Where will I receive chemotherapy treatment?
Many of our patients receive chemotherapy here in our offices. Our oncology nurses are trained in the administration of the latest chemotherapy treatments. Occasionally, due to insurance reasons, we will schedule our patients for their treatment on an out-patient basis at one of the hospitals where our physicians have privileges.

I need to see a hematologist and understand Astera physicians treat not only oncology (cancer) patients, but also hematology (blood) disorders. Can you please explain?
Our physicians have extensive knowledge and experience in the diagnosis and treatment of diseases of the blood, ranging from anemia to clotting problems. We treat many hematology patients with non-cancerous blood disorders. (It is very common for oncologists to also practice hematology, as many of the side effects of chemotherapy are blood related, for example, anemia and neutropenia.)

What hospitals are Astera affiliated with?
We are affiliated with the following New Jersey hospitals: JFK Medical Center in Edison; Robert Wood Johnson University Hospitals in Hamilton, New Brunswick and Somerset; and Saint Peter's University Hospital in New Brunswick. We are not able to treat patients at other hospitals, as we are not on staff.

I am aware that I will require chemotherapy treatment and am concerned about the co-payments. Are there any assistance programs available?
In the event that you will be receiving chemotherapy treatments, our financial counselors may contact you prior to your first treatment to discuss assistance programs that are available. In cases of need, we will discuss your options regarding assistance from several organizations.