Frank L. Franzese, M.D.
Debra Freeman. M.D.
Craig R. Miercort, M.D.
Robert J. Miller, M.D.
Zucel Solc, M.D.
Board Certified in Radiation Oncology

6600 66th St. N.
Pinellas Park, FL 33781

PLEASE FILL OUT THE ENCLOSED FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT

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. Support groups are also a vital part of WellSpring and we offer meetings for patients, caregivers and families. Please ask any questions you might have at any time during your treatment with us at WellSpring. We are open Monday-Friday from 8:00a.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., Debra Freeman, M.D., Craig R. Miercort, M.D. Robert J. Miller, M.D. & Zucel Solc, M.D.

WellSpring Oncology

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____ ( ) _____ HOME

Patient's Name: _____ ( ) _____ CELL / ALT
Last First M.I.

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City State Zip *City State Zip*

_____ _____ M F _____ Single ❑ Married ❑ Divorced ❑ Widowed ❑
Date of Birth Age Sex Social Security Number Marital Status

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

Race: Caucasian _____ Black _____ Asian _____ Hispanic _____ Other (specific) _____

Employer: _____ (_____)_____
Name Telephone

Responsible Party: _____ _____ (_____) _____
Name Relationship Telephone

Emergency Contact: _____ _____ (_____) _____
Name Relationship Telephone

Referring M.D. _____ Phone Number: _____

Primary Care M.D. _____ Phone Number: _____

Other physicians involved in your **cancer** care: _____ Phone Number: _____

~ If you have Hospice or are in a Skilled Nursing Facility Please Notify the Front Desk ~

PLEASE FILL OUT INSURANCE INFORMATION

Primary Ins: _____ Telephone: (_____)_____

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

Secondary Ins: _____ Telephone: (_____)_____

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

1. I authorize Wellspring Cancer Center to bill my insurance company for services rendered. I understand that I will be responsible for co-payments at the time of service. I understand that I am responsible for charges not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to WellSpring Cancer Center, L.L.C.
3. I authorize payment to be made directly to Wellspring Cancer Center as assignment is indicated by my insurance company. 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 Wellspring Cancer Center. This assignment will remain in effect until revoked by me in writing.

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.

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

_____ _____ a.m./p.m.
Responsible Party Signature Relationship Date/Time: Circle one

_____ _____ a.m./p.m.
Witness Date/Time:

WSCC 2/08

Employee Initials
_____

WellSpring Oncology
Caring for People with Cancer

6600 66th Street North
Pinellas Park, FL 33781

Frank P. Franzese, MD
Debra Freeman, MD
Robert J. Miller, MD
Craig R. Miercort, MD
Zucel Solc, MD

Consent to Use and Disclose Health Information

I understand that Wellspring Oncology is a healthcare provider and that they may share my health information for treatment, billing and healthcare operations.

I hereby authorize all Wellspring Oncology physicians and/or staff to discuss my medical condition and treatment plan with the following friends, family members or caregivers:

Name of person	Relationship to patient	Phone Number
Name of person	Relationship to patient	Phone Number
Name of person	Relationship to patient	Phone Number
Name of person	Relationship to patient	Phone Number
Name of person	Relationship to patient	Phone Number

I understand this consent to disclose my health information may be revoked and/or changed in writing at any time. **Unless the above names are changed by me, this authorization will never expire.**

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Patient Name

If signed by legal representative, relationship to patient: _____

DIRECTIONS TO WELLSPRING

6600 66th Street North
Pinellas Park, FL 33781

We are at the cross roads of 66th Street North and 66th Avenue North.

From the South: Take any east-west avenue to 66th Street North and turn north on 66th Street North. We are the cross street just north of the Tampa Bay Orthopedic Surgery Center with a teal colored metal roof. Turn left on 66th Avenue and then right in the second driveway.

North County: Go south on U.S. 19 and get off on the St. Pete Beach exit. This is 66th St. North. Travel about 5 miles past Bryan Dairy Rd. and Park Blvd to 66th Avenue North, turn right and then right into the second driveway.

Clearwater: Go south on Belcher Rd. and turn left on Park Blvd. and take it to 66th Street North. Turn right by the St. Pete College Health Education Building. Go down 3 blocks to 66th Avenue North and turn right and then right into the second driveway.

I-275: Take the Park Blvd/Gandy Blvd exit and head west on Park Blvd. to 66th Street North. Turn left or go south on 66th Street North to 66th Avenue (about 3 blocks) and turn right and then right into the second driveway.

WellSpring Oncology
Caring for People with Cancer

Welcome to WellSpring Oncology! We appreciate your confidence in choosing our organization to provide you with the best radiation treatment and care available. We will make every effort to offer you care and compassion during your course of treatment and follow-up.

We understand the expense associated with the treatment of cancer can be overwhelming, especially if surgery and chemotherapy is also involved. We will always bill your insurance first. If there is any patient responsibility we will bill you. We offer various payment methods including credit card, check, debit card, cash, money order and payment plans for your co-pays and deductibles due. If you are a self-pay patient, please see me for assistance.

Should you have the need for financial assistance, please see the list of organizations below and attached:

Chronic Disease Fund:	1-877-968-7233	www.pparx.org
Partnership for Prescription Assistance:	1-888-477-2669	www.copays.org
Patient Advocate Foundation:	1-800-532-5274	www.patientadvocate.org
American Cancer Society:	1-800-227-2345	www.cancer.org
The HealthWell Foundation:	1-800-675-8416	www.healthwellfoundation.org
Senior Life Services:	1-800-548-3249	

Our payment plans do not charge interest and are handled “in-house.” Please see me for details should you be interested in arranging a payment plan.

Warmest regards,

Janet McNamara
Patient Financial Coordinator
(727) 344-6240

WellSpring Oncology
Caring for People with Cancer

Robert Miller, MD Frank Franzese, MD Zucel Solc, MD
Craig Miercort, MD Debra Freeman, MD

Health History Questionnaire

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

Referring Physician:_____ **Family Physician**: _____

Other physicians involved in your cancer care:_____

We will keep your physicians updated on your cancer care. Please list any physicians you do **not** want us to release updates to. _____

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 the physician please take a moment to provide the following information.

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 and treatment including surgery, medications, **chemotherapy or radiation if applicable**).

_____
_____
_____
_____
_____

Allergies: ____Yes ____No ***(If yes, please list below)***

Type of Allergy	Description of Reaction

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

Medication/Supplement Dose Frequency (times per day)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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

__Diabetes
__Glaucoma/Cataracts
__Thyroid Disease
__Asthma
__Sinusitis
__Pneumonia
__Bronchitis
__Tuberculosis
__COPD/Emphysema
__Heart Disease
__Pacemaker/Defibrillation
__High Blood Pressure
__High Cholesterol
__Heart Attack
__Atrial Fibrillation
__Heart Murmur
__Ulcers
__Heartburn/Reflux
__Irritable Bowel Syndrome
__Colitis/Crohn's
__Diverticulitis
__Hemorrhoids
__Jaundice/Liver Disease
__Prostate Problems/BPH
__Kidney Disease
__Kidney Stones
__Stroke
__Alzheimer's/Dementia
__Seizures/Epilepsy
__Emotional/Mental Problems
__Osteoarthritis
__Rheumatoid Arthritis
__Blood disorder/Blood Clots
__Bone Disease/Osteoporosis
__Anemia
__Infectious Disease (Specify _____)
__Cancer (Type and Treatment)_____
_____
__Other_____
__Other_____

Lifetime Surgical Procedures (including biopsies), Tests/Exams (colonoscopy, mammograms, etc), and Hospitalizations:

What (Procedure)?	Where was it done?	When was it done (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 Major Medical Illness (Including Cancer and Cause and Age of Death):

Father: _____

Mother: _____

Grandparents: _____

Siblings: _____

Children: _____

Current (within the last month) Review of Systems (Check all that apply)

Constitutional
- [ ] Appetite Loss
- [ ] Fatigue
- [ ] Fever
- [ ] Weakness
- [ ] Weight Change
- [ ] Chills
- [ ] Night Sweats

Eyes
- [ ] Blurred vision
- [ ] Excessive tearing
- [ ] Double vision
- [ ] Visual Difficulties

Ear/Nose/Mouth/Throat
- [ ] Difficulty swallowing
- [ ] Pain swallowing
- [ ] Ear pain
- [ ] Nose bleeds
- [ ] Esophagitis
- [ ] Hearing ability
- [ ] Mouth dryness
- [ ] Oral bleeding
- [ ] Ear infections
- [ ] Sinus infections
- [ ] Phlegm production
- [ ] Mouth sores
- [ ] Taste altered
- [ ] Ringing in ears

Neck
- [ ] Masses
- [ ] Muscle Weakness
- [ ] Pain
- [ ] Range of Motion
- [ ] Swelling

Skin
- [ ] Hair loss
- [ ] Blisters
- [ ] Bruising
- [ ] Dry Skin
- [ ] Facial burning
- [ ] Nails
- [ ] Light sensitivity
- [ ] Itchy skin
- [ ] Rash/Hives

Breast
- [ ] Breast masses
- [ ] Nipple discharge
- [ ] Nipple changes
- [ ] Pain

Heart
- [ ] Arrhythmias
- [ ] Chest pain
- [ ] Leg swelling
- [ ] B/P drop on rising
- [ ] Palpitations

Respiratory
- [ ] Cough
- [ ] Shortness of breath
- [ ] Coughing up blood
- [ ] Pleuritic chest pain
- [ ] Wheezing

Gastrointestinal
- [ ] Abdominal pain
- [ ] Change in bowel habits
- [ ] Constipation
- [ ] Diarrhea
- [ ] Heartburn
- [ ] Vomiting blood
- [ ] Feeling full
- [ ] Dark/Bloody Stools
- [ ] Hemorrhoids

Genitourinary (Male only)
- [ ] Urgency
- [ ] Burning with urination
- [ ] Frequency
- [ ] Blood in urine
- [ ] Impotence
- [ ] Incontinence
- [ ] Night urination
- [ ] Scrotal swelling

Hematologic/Lymphatic
- [ ] Easy bruising
- [ ] Lymph node swelling
- [ ] Frequent infections

Genitourinary (Female Only)
- [ ] Urinary burning
- [ ] Frequency
- [ ] Genital masses
- [ ] Blood in urine
- [ ] Incontinence
- [ ] Sexual dysfunction
- [ ] Urgency
- [ ] Vaginal discharge/bleeding
- [ ] Age started period ____
- [ ] Menopause Age ____
- [ ] Birth Control/#Years ____
- [ ] Hormones/#Years ____
- [ ] Pregnancies/Live birth ____
- [ ] Age of 1st pregnancy ____
- [ ] ***Could you be pregnant?***
- [ ] ***Counseling required?***

Musculoskeletal
- [ ] Arthritis
- [ ] Bone pain
- [ ] Joint pain
- [ ] Muscle weakness
- [ ] Range of motion

Neurologic
- [ ] Confusion
- [ ] Dizziness
- [ ] Difficulty sleeping
- [ ] Numbness/tingling
- [ ] Paralysis
- [ ] Seizures
- [ ] Sensory problems
- [ ] Headaches

Psychiatric
- [ ] Delusions
- [ ] Hallucinations
- [ ] Depression
- [ ] Mood swings

Endocrine
- [ ] Diabetes
- [ ] Hot flashes
- [ ] Menstrual irregularities
- [ ] Thyroid disease

Do you have written Advance Directives? _____Yes _____ No If yes, for your protection, please bring us/front desk 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, for your protection, please bring us/front desk a copy for our records.

Have you appointed anyone as Power of Attorney for you? _____Yes _____No

If yes, who? _____ Relationship to you _____

Do you reside in a nursing home? If so, which home? _____

Are you being cared for under Hospice coverage? _____Yes _____No

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 and/or Signature of Person (relationship) filling out Form/Date

_____

Reviewed with Patient by Physician/Nurse and Date

WellSpring Oncology
Caring for People with Cancer

6600 66th Street North Pinellas Park, FL 33781
Phone 727-343-0600 Fax 727-329-5421

AUTHORIZATION TO REQUEST MEDICAL RECORDS

Name: _____ Date of Birth: _____

SSN#: _____ Telephone #: _____

I authorize (list all physicians) _____ _____

_____ _____ _____

to disclose to Wellspring Oncology my medical information for my treatment at Wellspring Oncology.

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/Disk [ ] Pathology Reports

[ ] Other Diagnostic Reports (please specify) _____

I understand this could include information of a super confidential 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

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.**

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

Your Name :

WellSpring Oncology
Caring for People with Cancer

6600 66th Street North
Pinellas Park, FL 33781

~~ ALL NEW PATIENTS ~~

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. Who referred you to us? (Answer as many as apply)

☐ Your Doctor's office **[Skip to #4]** ☐ Self-referral **[Continue with #2]**

2. How did you hear about us?

☐ Friends/Family **[Skip to #4]**
☐ Radio **[Skip to #4]**
☐ TV **[Skip to #4]**
☐ Newspaper **[Skip to #4]**
☐ Community event **[Skip to #4]**
☐ Internet search **[Continue with #3]**
☐ Other _____ **[Skip to #4]**

3. What words did you use in your Internet search to find WellSpring Oncology?

_____ _____ _____ _____

4. Where did you get our phone number to make your initial appointment?

☐ Doctor gave me your info
☐ Phonebook
☐ Radio/TV
☐ Internet search
☐ WellSpring Oncology website
☐ News story
☐ Community event
☐ Other _____

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

_____ _____

6. Have you seen our television commercials?

YES NO

If "Yes" what station or program? _____

7. Have you seen/heard or read an interview with any of our physicians?

YES NO

If "Yes" which TV station, radio station, newspaper or magazine? _____

8. Why did you choose WellSpring Oncology?

☐ Great doctors
☐ State of the art technology
☐ Caring staff
☐ Beautiful facility
☐ other _____

THANK YOU!

WellSpring Oncology
Caring for People with Cancer

6600 66th Street N Pinellas Park, FL

PATIENT'S RIGHTS AND RESPONSIBILITIES

RIGHTS

AS A PATIENT, I HAVE THE RIGHT TO:

1. Full information about my rights and responsibilities as a patient.
2. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
3. An explanation of all rules; regulations and services provided by WellSpring Cancer Center, L.L.C., the days and hours of service and provisions for possible emergency care, including telephone numbers.
4. Choose the type of medical plan that is best suited to my particular situation and work with the physician members within my healthcare plan.
5. Participate in development of a plan of care including Advance Directives.
6. Refuse participation in any protocol or aspect of care including investigational studies and freely withdraw my previously given consent for further treatment.
7. Disclosure of any teaching programs, research or experimental programs in which the facility is participating.
8. Full financial explanation and payment schedules prior to beginning treatment.
9. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age.
10. Be treated with courtesy, dignity and respect of my personal privacy by all employees of WellSpring Cancer Center, L.L.C.
11. Be free of physical/mental abuse and/or neglect by all employees of WellSpring Cancer Center, L.L.C.
12. Complain or file grievance with the Patient Representative or Office Manager without fear of retaliation or discrimination.
13. Confidential treatment of my condition, medical record and financial information.
14. Access to my personal records and obtain copies upon written request.
15. Assistance and consideration in the management of pain.

RESPONSIBILITIES

AS A PATIENT, I HAVE THE RESPONSIBILITY TO:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.
2. If required by my health plan, obtain proper referrals/authorizations for treatment and/or physician visits from my Primary Care Provider.

3. Participate in developing a Plan of Care and provide copies of any Advance Directives or Living Will to my physician.
4. Assist in maintaining a safe, peaceful and efficient ambulatory environment.
5. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed patient responsibility/co-pay during my office visit.
6. Contact the office when unable to keep a scheduled appointment.
7. Cooperate in the planned care and treatment developed for me.
8. Request more detailed explanations for any aspect of service I don't understand.
9. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.
10. Relate my levels of discomfort and/or pain and perceived changes in my pain management to my physician.
11. Inform my physician or nurse when I am going to need a prescription refill before my supply is gone.
12. Communicate any temporary or permanent change in my address or telephone number, which might hinder contact by the staff.