Delfino M. Crescenzo, M.D., F.A.C.P. 161-50 92nd Street Howard Beach NY 11414 Tel. 718-848-0475 Fax 718-848-5830

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	M.I.:	Previous Name (If Applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) o Voice o Text		If Voice, Please Select Preferred Number: o Home o Cell o Work	
Marital Status: o Married o Single o Divorced o Widow	Date of Birth:	Sex: o Male o Female	
Family Physician or PCP:	Telephone #:		
Employer Name:	Emergency Contact Relationship to Patient:		
Emergency Contact Name:	Emergency Contact Phone #:		

RESPONSIBLE PARTY- IF THE PATIENT IS A MINOR (UNDER THE AGE OF 18), THE PARENT OR GUARDIAN BRINGING THE PATIENT IN WILL BE LISTED AS THE GUARANTOR

Last Name:	First Name:	
Date of Birth:	Telephone:	Cell Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

ADDITIONAL INFORMATION (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	Can we leave a message regarding your medical care & test results? o Yes o No Where?: o Home o Cell o Work
Race (Please Select): o White o American Indian or Alaska Native o Asian o Hispanic o Black or African American o Native Hawaiian or Pacific Islander o Other o Decline	Ethnicity (Please Select One): o Hispanic or Latino o Not Hispanic or Latino o Decline
Preferred Language (please select one): o English o Bosnian o Indian (including Hindi & Tamil) o Sign Language o Spanish o Russian o Other	
Preferred Pharmacy Name & Location:	

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy ID #:	Policy ID #:
Patient Relationship to Policy Holder: DOB:	Patient Relationship to Policy Holder: DOB:

I certify that I have read and agree to Dr. Crescenzo's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibili regardless of insurance coverage. I hereby assign to Dr. Crescenzo all monies to which I am entitled for medical expenses related to the services performed by Dr. Crescenzo but not to exceed my coverage to Dr. Crescenzo. I authorize Dr. Crescenzo to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outsid collection agency. A $35.00 returned check fee will be charged for insufficient funds. I choose to receive communications from Dr. Crescenzo by text or e-mail at the numbe or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there may be a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Dr. Crescenzo. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for the related services. I certify that I may sign an ABN form fo services that are not covered by Medicare but I choose to receive.

I have reviewed a copy of Dr. Crescenzo Privacy Notice. (Initials) X _____ Date: _____

Signature of Responsible Party: X _____ Date:

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Hematology/ Oncology

FAMILY HISTORY - HEALTH HISTORY QUESTIONNAIRE

PLEASE FILL THIS FORM OUT AS COMPLETELY AS POSSIBLE

Check below to report problems your family members have had. Please state the age when they had the problems if you know it. Please check of one if it applies, or fill in family relation if choosing other, i.e. Aunt, Uncle, etc. ☐ I am adopted it doesn't apply.

DISEASE / DISORDER	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON	OTHER
DIABETES							
HEART DISEASE							
HYPERTENSION							
KIDNEY DISEASE							
STROKE							
BLEEDING DISORDER							
BLOOD COUNT DISORDER							
CLOTTING DISORDER							
LEUKEMIA							
BREAST CANCER							
COLON CANCER							
LUNG CANCER							
OVARIAN CANCER							
LYMPHOMA							
MELANOMA							
MULTIPLE MYELOMA							
SARCOMA							
Alive -Yes, no or N/A							
Other Cancer Specify							

ONCOLOGIST / REFERRING DOCTOR

DOCTOR NAME	ADDRESS	TEL.	FAX.

TREATMENT TYPE	WHEN DATE	WHERE	PHONE NUMBER
SURGERY			
CHEMOTHERAPY			
RADIATION			
HORMONAL THERAPY			
OTHER SPECIFY			

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SOCIAL HISTORY – Check all that apply

I currently live	Alone	Family	Friends	Significant other
Do you have children?	Yes	No	Ages	
Occupation				
Do you ever drink alcohol?	Yes	No	Socially	
If yes, please indicate the quantity per week of each		Wine	Beer	Liquor
Are You Sexually Active?	Yes	No	Not Currently	
If yes, is your partner	Male	Female	None	
Type of Birth Control	Not having	Condom	Injection	IUD
Other:	Oral	Patch	Post-Menopausal	None
Drug usage?	Yes	No	If yes, how many times per week?	
What type of recreational drugs?				
Do you smoke?	Yes	No	If yes, how many per week?	
Never smoked	Former	Smoke some days	Exposed to second hand smoke	
How many years did you smoke?		If you quit, how long?		
Do you use smokeless tobacco?		How many times:/day /week		
Are you ready to quit?		Do you need help quitting?		

SURGICAL / HOSPITAL HISTORY

SURGERY	HOSPITAL	DATE

Tranfusions

Have you ever had a blood transfusion?	When/Where?

Which doctor should we send information about your visits at Dr. Crescenzo?

Name:			Specialty
Address:			Phone #:
			Fax#:
City	State	Zip	

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MEDICATION LIST

NAME OF MEDICATION	DIRECTIONS	PRESCRIBED BY & WHEN

CURRENTLY ON TREATMENT? ☐ YES ☐ NO IF YES, LIST BELOW

WHAT TYPE OF TREATMENT	WHERE DO YOU RECEIVE IT	TREATING DOCTOR

Print Name of person completing this form –

Date

Relationship to patient

Delfino M. Crescenzo, M.D., F.A.C.P.
161-50 92nd Street
Howard Beach NY 11414
Tel. 718-848-0475 / Fax: 718-848-5830

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION POLICY

Patient Name: _____ Date: _____

It is our policy not to release confidential and/ or unauthorized information by home telephone, answering machine, work telephone, voice mail, and cell phone and /or by mail, or someone other than any persons listed below. Information also will not be given or left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please indicate: i.e. Spouse, Boyfriend, Girlfriend, Parent, Grandparent, etc.

I authorize the staff of Delfino M. Crescenzo, M.D. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Please list names of authorized people we may leave messages with:

_____ _____Yes _____No
Name Relationship
Contact number:_____

_____ _____Yes _____No
Name Relationship
Contact number:_____

Please list names of authorized people we may give medical records to:

_____ _____Yes _____No
Name Relationship
Contact number:_____

_____ _____Yes _____No
Name Relationship
Contact number:_____

Please list names of authorized people we may release protected health information:

_____ _____Yes _____No
Name Relationship
Contact number:_____

_____ _____Yes _____No
Name Relationship
Contact number:_____

Who may we discuss your financial situation with?

_____ _____Yes _____No
Name Relationship
Contact number:_____

_____ _____Yes _____No
Name Relationship
Contact number:_____

Signature(Patient Guardian) _____ Date: _____

Delfino M. Crescenzo, MD, FACP
Medical Oncology - Hematology
Howard Beach NY 11414
Tel 718-848-0475 Fax 718-848-5830

FINANCIAL POLICY

We are pleased that you have chosen our office to be your healthcare provider. We will try to always give you the best service.

In order to maintain an excellent service level, it is necessary for us to have the following policies:

- **Co-Pays are due at the time of every office visit.**
- **Before a patient receives chemotherapy**: an appointment or phone call to our billing department for insurance clarification is recommended. A meeting with the patient or financial guarantor should be arranged to discuss insurance payment. We will make every effort to work with our patients on an individual basis. (For qualifying patients we will help to search for grants to help cover any co-pays and co-insurance you may owe.)
- **It is the patient's responsibility** to obtain the necessary referrals for each visit. Most primary care physicians will not back date referrals, or issue at the time of your visit. If you have not obtained a referral you will need to reschedule your appointment. The office reserves the right to reschedule your appointment until the referral is obtained. You can pay for the visit not using your insurance.
- **For your convenience we accept**: cash, checks, VISA, Master Card, Debit Card, Discover, American Express and Personal Checks.
    - There will be a fee of $35.00 for insufficient funds returned checks.
    - There will be a $7.00 processing fee for co-pays not paid at the time of visit.
- **It is the patient's or the patient's care giver responsibility** to advice the office of any changes in insurance or address and phone number.
- **Prompt payment of your co-payments and balances** is appreciated as it allows the office to provide ongoing high quality care to our patients.

YOUR INSURANCE

We always try to help our patients receive maximum benefits provided by their health insurance, but the policy is ultimately a contract between you and your insurance company, Because of this reason it is your responsibility to know what the specifics of your policy are included co-pays, deductibles, and limitations of service, non-covered services and referral policies.

Regardless of your insurance coverage all expenses incurred as a result of services provided by Delfino M. Crescenzo are ultimately the responsibilities of the patient.

Our billing department is available to answer any questions you may have regarding either your patient or insurance balance. Our office staff will work with any patient who requests a payment plan.

I have read, understand, and received a copy of the entire financial policy of Delfino M. Crescenzo, MD and agree to its terms.

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Witnessed by**

Delfino M. Crescenzo, MD, FACP
Medical Oncology - Hematology
Howard Beach NY 11414
Tel 718-848-0475 Fax 718-848-5830

OFFICE POLICIES

OFFICE APPOINTMENT POLICY

Appointments - are required for all services in the office. This enables us to maintain availability for emergency and urgent appointments.

No Shows - Cancellations
For any patient that does not keep their scheduled appointment and does not give the office at least a 24 hour notice, we charge the following fees: Initial: $75.00 For follow up: $50.00.

LATENESS POLICY

If a patient is more than 15 minutes late their appointment will be rescheduled for the next available appointment. If you are going to be more than 15 minutes late please call the office at least 1 hour before your appointment time or as soon as possible so that we may move your appointment and check for same day availability.

OFFICE VOICE MAIL POLICY

Please do not leave any urgent messages regarding medical issues on the office voice mail. If you have an urgent or medical emergency off hours, please call 911. For all non-urgent matters ie: scheduling appointments, referrals, authorizations, etc. you may leave a message on the voice mail. The messages will be retrieved the next business day. If it is the weekend or after hours and you need to contact Dr. Crescenzo for an urgent matter only please call 800-846-5064 for our off hours service.

MEDICAL RECORDS – FORMS COMPLETION POLICY

In fairness to all patients, we are not able to accommodate completing forms while you wait. You may drop off, mail in or fax to our office and we will contact you within one week or upon completion. All medical records need to be requested at least 1 week in advance. A $10.00 fee will be applied for all forms, fmla, disability, clearance and other medical forms.

PRESCRIPTION REFILLS

All prescriptions will be done within 48 hours. Please do not wait until you have no medication left and check to make sure you will have enough for weekends and holidays. If your primary care doctor can refill the medication being requested please call your doctor's office. Dr. Crescenzo will only refill the medications he is treating you for. You can drop off, mail in, fax or call for your request.

I have read, understand, and received a copy of the entire financial policy of Delfino M. Crescenzo, MD and agree to its terms. We greatly appreciate you following our policies, this will enable us to give you the best care possible.

_____ _____
Patient Signature **Date**

_____ _____
Print Name **Witnessed by**

Delfino M Crescenzo, MD, FACP
161 50 92nd Street
Howard Beach NY 11414
Tel. 718-848-0475 Fax. 718-848-5830

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State/Zip: _____

I authorize the release of my health information to (Name of entity, or facility to whom information will be sent to:

_____ Tel. _____

Address: _____ City, State, Zip: _____

□ Notes □ Pathology Reports □ Radiology Reports □ Laboratory Reports □ Insurance

□ Entire Medical Records from _____ to _____ □ Other: _____ □ Paper □ Electronic

I am requesting my health information be released from (Name of facility or health provider): _____

_____

To: Delfino M. Crescenzo, M.D. For: □ Medical Care / Treatment □ Other (specify)_____

Restrictions:

Only medical records originated through this healthcare office will be copied, unless otherwise requested.

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released, I must do so in writing to the Office Med. Records department. Revocation will not apply to information already sent.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Dr. Crescenzo's office shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS and additional HIPAA release of medical information form will be requested. Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- Dr. Crescenzo's office may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on___/_____/_____ {if date not completed / one year after signed}

_____ _____

Patient / Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name **Relationship to patient**

Retain this form in the patient's medical record and provide a copy to the patient.

DELFINO M. CRESCENZO, M.D., F.A.C.P.
HEMATOLOGY – ONCOLOGY
16150-50 92nd Street, Howard Beach NY 11414
Tel. 718-848-0475
Fax. 718-848-5830

Credit Card on File Billing Authorization Form

Dr. Delfino M. Crescenzo is offering a secure and convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are responsible. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed to and processed by your insurance carrier, and the insurance portion of the claim has posted to your account, or in the event that your insurance does not cover services provided at the time of service.

I _____ authorize Dr. Delfino M. Crescenzo to capture my credit card information and securely store my credit card on file.

I agree Dr. Delfino M. Crescenzo may charge my credit card on file for the balance due when they receive a copy of the EOB. This authorization relates to all balances not covered by my insurance company for services provided by Dr. Delfino M. Crescenzo. This could be amounts resulting from balances related to copayment, deductible, co-insurance, or non-covered services but is not limited to these scenarios.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Dr. Delfino M. Crescenzo. Written notice must be submitted to:

Dr. Delfino M. Crescenzo, 161-50 92nd Street, Howard Beach NY 11414.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

CARDHOLDER INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email _____ Direct Telephone: ( )_____-_____

CREDIT CARD INFORMATION

Credit Card Type: ☐ **MasterCard** ☐ **Visa** ☐ **American Express** ☐ **Discover Card**

Number:_____

Expiration Date:_____ Security Code:_____

Cardholder Signature X_____ Date____/____/_____