SHAZIA ZAFAR, MD
Hematology/Oncology
Board Certified
Clinical Assistant Professor
Nova Southeastern University

LAST NAME:_____ FIRST: _____M.I.:_____

SS#:_____ D.O.B:_____ SEX:_____

LOCAL ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

CELL:_____ HOME PHONE:_____

EMAIL ADDRESS_____

PRIMARY LANGUAGE SPOKEN:_____

If you are a seasonal resident and also reside in another state other than Florida, please list your address
ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

NEXT OF KIN:_____RELATIONSHIP:_____PHONE:_____

ADDRESS:_____

DO YOU HAVE LIVING WILL? YES? NO

EMPLOYER: _____PHONE:_____

ADDRESS:_____

PRIMARY PHYSICIAN:_____ PHONE:_____

ADDRESS:_____

PURPOSE OF APPOINTMENT: _____

PATIENT SIGNATURE:_____DATE:_____

SOUTHWEST FLORIDA CANCER CARE
Suite 110, 1000 North Hiatus Road, Pembroke Pines, FL 33026
Telephone 954.883-2500

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Today's Date: _____ Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY: _____

PROCEDURE/ SURGICAL HISTORY: _____

ALLERGIES (Please list any allergies): _____

LIST FAMILY HISTORY:

	Diseases or Illness	Age or Age of Death	Reason for Death
Mother:			
Father:			
Paternal Grand Mother:			
Paternal Grand Father:			
Maternal Grand Mother:			
Maternal Grand Father:			
Siblings (Brother/ Sister):			
Siblings (Brother/ Sister):			
Siblings (Brother/ Sister):			

SOCIAL HISTORY: _____

_____ _____

Patient's Signature Date

Today's Date: _____ Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS (CHECK LIST):

General-
___Weight loss or gain
___Fatigue
___Fever or chills
___Weakness
___Trouble sleeping

Skin-
___Rashes
___Lumps
___Itching
___Dryness
___Color changes
___Hair and nail changes

Head-
___Headache
___Head injury
___Neck Pain

Ears-
___Decreased hearing
___Ringing in ears
___Earache
___Drainage

Eyes-
___Vision Loss/Changes
___Glasses or contacts
___Pain
___Redness
___Blurry or double vision
___Flashing lights
___Specks
___Glaucoma
___Cataracts
___Last eye exam

Nose-
___Stuffiness
___Discharge
___Itching
___Hay fever
___Nosebleeds
___Sinus pain

Throat-
___Bleeding
___Dentures
___Sore tongue
___Dry mouth
___Sore throat
___Hoarseness
___Thrush
___Non-healing sores

Neck-
___Lumps
___Swollen glands
___Pain
___Stiffness

Breasts-
___Lumps
___Pain
___Discharge
___Self-exams
___Breast-feeding

Respiratory-
___Cough
___Sputum
___Coughing up blood
___Shortness of breath
___Wheezing
___Painful breathing

Cardiovascular-
___Chest pain or discomfort
___Tightness
___Palpitations
___Shortness of breath with activity
___Difficulty breathing lying down
___Swelling
___Sudden awakening from sleep with shortness of breath

Gastrointestinal-
___Swallowing difficulties
___Heartburn
___Change in appetite
___Nausea
___Change in bowel habits
___Rectal bleeding
___Constipation
___Diarrhea
___Yellow eyes or skin

Urinary-
___Frequency
___Urgency
___Burning or pain
___Blood in urine
___Incontinence
___Change in urinary strength

Vascular-
___Calf pain with walking
___Leg cramping

Musculoskeletal-
___Muscle or joint pain
___Stiffness
___Back pain
___Redness of joints
___Swelling of joints
___Trauma

Neurologic-
___Dizziness
___Fainting
___Seizures
___Weakness
___Numbness
___Tingling
___Tremor

Hematologic-
___Ease of bruising
___Ease of bleeding

Endocrine-
___Head or cold intolerance
___Sweating
___Frequent urination
___Thirst
___Change in appetite

Psychiatric-
___Nervousness
___Stress
___Depression
___Memory loss

_____ _____

Patient's Signature Date

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MEDICATION LIST

PATIENT NAME:_____

Date of Birth:_____ Phone: (_____) _____- _____

ALLERGIES:_____

	MEDICATION NAME	DOSE	TIMES PER DAY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

_____ _____

Patient's Signature Date

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Telephone 954.883-2500

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REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM:_____
Name of Physician, Hospital or Facility

ADDRESS:_____

_____

Phone: (_____) _____- _____

Fax: (_____) _____- _____

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment, be released to:

SOUTHWEST FLORIDA CANCER CARE
Suite 110
1000 North Hiatus Road
Pembroke Pines, FL 33026
Telephone 954.883-2500 | Fax 954.538.0304

This authorization releases my medical records for the following designated purpose:_____

_____

I understand that I am entitled to receive a copy of this release.

_____ _____ _____
Patient's Signature Printed Name Date

Date of Birth: _____

_____ _____
Print Name of Legal Guardian (relationship), if applicable Witness

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INSURANCE INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Insurance Information: _____

I hereby authorize and assign payment to Shazia Zafar MD LLC for all insurance medical benefits. I also understand my responsibilities of payment for any and all charges not payable under this assignment. Payment, including copays, is expected in full at the time services are rendered.

I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account for any professional services rendered including any fees incurred for the collection of debt.

I hereby authorize Shazia Zafar, MD to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____	_____	_____
Patient's Signature	Printed Name	Date

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Hematology/Oncology
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NO SHOW POLICY

I _____ understand that there will be a $50.00 no show fee that I am fully responsible for if I do not call and cancel my appointment at least 24 hours in advance.

_____	_____	_____
Patient's Signature	Printed Name	Date

Southwest Florida Cancer Care
SHAZIA ZAFAR, MD
Suite 110, 1000 North Hiatus Road, Pembroke Pines, FL 33026
Telephone 954.883-2500 | Fax 954.538.0304

NOTICE OF PRIVACY PRACTICES Of SHAZIA ZAFAR, MD

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

Effective Date of This Notice: 09/16/2013

If you have any questions or requests, please contact Privacy Officer at 954-883-2500

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information or "PHI" for short and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. Our practice is required by law to abide by the terms of this Notice.

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

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders: We may contact you to provide appointment reminders and may, in some instances, leave a message on your answering machine.

Treatment: We may use health information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, your doctor may share medical information about you if you are referred to another doctor. Your doctor might also disclose your PHI to others outside his/her practice including a designated personal representative (as long as they are approved by you), a pharmacist, medical equipment supplier or any other healthcare professional who needs your information to continue your care.

Payment: We may use and disclose medical information about you to obtain payment for the services provided to you. For example, we will send invoice (paper or electronically) to your health insurance company to provide them with the necessary information for payment of our services or our office might contact your insurance company to seek approval for tests we deem necessary to determine a course of treatment for which the insurance company and their agents require us to disclose your personal health information. Our office may give your personal health information (not diagnosis) to a collection department or agencies.

Regular Health Care Operations: We may use and disclose health information for our own operations to facilitate the function of our office, diagnostic centers or laboratory and as necessary to provide quality care to all of our patients. Your doctors' healthcare operations include such activities as:

- Quality assessment and improvement activities, which may involve outside agencies.
- Activities designed to improve health or reduce healthcare costs.
- Professional review and performance evaluations by doctors reviewing the services provided to you, and by accountants, lawyers and others who assist us in complying with applicable laws.
- Review and auditing, including compliance reviews, medical reviews and compliance programs.
- Providing training to doctors, nurses, or non-healthcare professionals to help them practice or improve their skills.

Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed. We will also use our professional judgment and our experience with common practice to make reasonable inferences

to your best interest in allowing a person to pick up prescriptions, medical supplies or drugs, X-rays or other similar forms of health information.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Disclosure to Department of Health and Human Services: We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Judicial and Administrative Proceedings: We may disclose personal medical information about you in response to an order of a court or administrative tribunal.

Law Enforcement: We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Deceased Person Information: We may disclose PHI about you to a coroner, medical examiners and funeral directors.

Organ Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research: Under certain circumstances, we may disclose health information about you for medical research.

Public Safety: We may disclose medical information about you to appropriate persons to prevent or lessen a serious and eminent threat to the health or safety of a person or the general public.

Workers' Compensation: We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Correctional Institutions: In certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

Business Associates: We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Change of Ownership: In the event we sold our practice or merged with another organization, your health information and records will become the property of the new owner.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, **in writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years, except for the disclosures of treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for PHI.
- You have the right to complain to us and/or the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

    - Privacy Officer
      SOUTHWEST FLORIDA CANCER CARE
      Suite 110, 1000 North Hiatus Road, Pembroke Pines, FL 33026
      Telephone 954.883-2500 | Fax 954.538.0304

- If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:
    - Privacy Officer

- **SOUTHWEST FLORIDA CANCER CARE**
  Suite 110, 1000 North Hiatus Road, Pembroke Pines, FL 33026
  Telephone 954.883-2500 | Fax 954.538.0304

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to the entire PHI we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have been provided the opportunity to review Dr. Shazia Zafar's Notice of Privacy Practices.

Patient's Signature	Printed Name	Date

I have been provided an opportunity to review the Privacy Notice and **DO NOT** wish to sign the acknowledgment form.

Patient's Signature	Printed Name	Date

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MALPRACTICE INSURANCE

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR (Shazia Zafar, MD) HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

Patient's Signature	Printed Name	Date