David L. Smith, M.D.
Thomas E. Le Voyer, M.D.
M. Umar Butt, M.D.
Fred S. Lee, M.D.

Primary Office and Correspondence:

⇒ 4001 W 15th Street, Ste. 425
Plano, TX 75093

NTSOA Satellite Offices:
- 5680 Frisco Square Blvd., Ste. 2500, Frisco, TX 75034
- 4510 Medical Center Dr., Ste. 302, McKinney, TX 75069
- 6750 N MacArthur Blvd., Ste. 257, Las Colinas, TX 75039
- 3537 S. I35E, Ste 220, Denton, TX 76210

Phone: 972.696.0030 Fax: 972.696.0037

Today's Date: _____ Name: _____ DOB: _____

What is the reason for your visit today? _____

Current Medication	Dose	Directions	Reason

Allergic To	Reaction

SURGICAL HISTORY

Surgeries	Date of Surgery

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ High blood pressure
- ☐ Heart attack
- ☐ High Cholesterol
- ☐ Irregular heart beat
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Recurrent urinary infections
- ☐ Hepatitis A, B, C
- ☐ Cirrhosis
- ☐ Headaches
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Seizures
- ☐ Meningitis
- ☐ Multiple sclerosis
- ☐ Anemia
- ☐ Blood clots
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Pituitary disease
- ☐ Adrenal disease
- ☐ Emphysema
- ☐ Asthma
- ☐ Hay Fever
- ☐ COPD
- ☐ Tuberculosis
- ☐ Pulmonary embolus
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Stomach ulcers
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Diverticulosis
- ☐ Irritable bowel syndrome
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lipoma
- ☐ Shingles
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Insomnia

Other Significant Past Medical History:

☐ _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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PERSONAL/FAMILY HISTORY

	You	Father's Side		Mother's Side		Sibling/Children	
Age of Diagnosis →	**Age**	**Age**	**Living?**	**Age**	**Living?**	**Age**	**Living?**
Example: Colon Cancer		**Aunt at 44**	**Yes**	**Grandfather at 65**	**Yes**	**Brother at 36**	**Yes**
Heart Attack							
Diabetes							
Stroke							
High Blood Pressure							
Blood Clots							
Breast Cancer							
Ovarian Cancer							
Prostate Cancer							
Pancreatic Cancer							
Melanoma							
Uterine (endometrial) Cancer							
Colon Cancer							
Stomach, Kidney/urinary, brain, OR small bowel cancer							
10 or more colon polyps found in a life time							
Other type of cancer (please write in)							

Are you of Ashkenazi Jewish decent? **Y** **N**

Age of first period (if applicable) _____

Age of First Child (if applicable) _____

Are you Menopausal? Y N

Have you ever had hormone replacement therapy? Y N

If you answered yes to Breast Cancer:

Was Tamoxifen or Herceptin prescribed? Y N

Breast cancer in both breasts? Y N

Have you had a surgical or needle biopsy of the breast? Y N

If yes, did the biopsy show atypical cells? Y N

Has anyone in your family had genetic testing for a hereditary cancer syndrome?

Y **N**

OFFICE USE ONLY

Confirmed TRIPLE NEGATIVE STATUS Y N

Patient meets NCCN criteria for testing Y N

Doctor informed patient meets NCCN criteria for hereditary cancer testing? Y N

NTSOA staff initials: _____

ALCOHOL, TOBACCO, CAFFEINE, AND DRUG USE

Present Use:			Type/Amount	Past Use:			Type/Date Stopped
Alcohol	Y	N	_____	Alcohol	Y	N	_____
Tobacco	Y	N	_____	Tobacco	Y	N	_____
Illegal Drugs	Y	N	_____	Illegal Drugs	Y	N	_____
Caffeine	Y	N	_____	Caffeine	Y	N	_____

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HEARTBURN & ACID REFLUX QUESTIONNAIRE

Are you taking medication for acid reflux?
Yes No Unknown
Names (e.g. Nexium, Prilosec, omeprazole, Tums, Zantac, Pepcid)
_____
Dose and frequency
_____

Do you have a gastroenterologist (GI doctor)?
Yes No Unknown
Name _____

Do you have an Ear Nose &Throat doctor (ENT)?
Yes No Unknown
Name _____

Have you ever had an upper endoscopy (EGD)?
Yes No Unknown
When? _____

Have you ever had a barium swallow?
Yes No Unknown
When? _____

Have you ever had acid reflux testing (pH test)?
Yes No Unknown
When? _____

Have you ever had esophageal testing (manometry)?
Yes No Unknown
When? _____

Do you have a hiatal hernia?
Yes No Unknown

Do you have Barrett's esophagus?
Yes No Unknown

Do you have a family history of esophageal cancer?
Yes No Unknown

Please circle the number that best reflects your symptoms using the scoring scale provided below.

Scoring Scale
0 = No symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activities
5 = Symptoms are incapacitating – unable to do activities

1. How bad is your heartburn (if not taking medications)?	0	1	2	3	4	5
2. Heartburn when lying down (if not taking medications)?	0	1	2	3	4	5
3. Heartburn when standing up (if not taking medications)?	0	1	2	3	4	5
4. Heartburn after meals (if not taking medications)?	0	1	2	3	4	5
5. Does heartburn change your diet (if not taking medications)?	0	1	2	3	4	5
6. Does heartburn wake you from sleep (if not taking medications)?	0	1	2	3	4	5
7. Do you have difficulty swallowing (if not taking medications)?	0	1	2	3	4	5
8. Do you have bloating or gassy feelings (if not taking medications)?	0	1	2	3	4	5
9. Do you have pain with swallowing (if not taking medications)?	0	1	2	3	4	5
10. If you take medication, does this affect your daily life?	0	1	2	3	4	5
11. How satisfied are you with your present condition?	Satisfied		Neutral		Dissatisfied	

Within the past month, how did the following problems affect you? Please circle one number for each symptom.

1. Hoarseness or other voice problems	0	1	2	3	4	5
2. Clearing throat	0	1	2	3	4	5
3. Excess throat mucus or postnasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquid, or pills	0	1	2	3	4	5
5. Coughing after eating	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in throat or lump in throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion or stomach acid coming up	0	1	2	3	4	5

OFFICE USE ONLY **NTSOA staff initials: _____**

Patient is possible candidate for anti-reflux surgery?	Y	N
Patient would like to discuss reflux options with the physician	Y	N
Doctor informed patient is interested in Reflux consult?	Y	N

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REVIEW OF SYSTEMS

Please circle (Y) or (N) any of the following that apply to symptoms you are recently or currently experiencing. Address each section carefully.

General

Change in appetite	Y	N
Chills	Y	N
Fever	Y	N
Fatigue	Y	N
Weight gain	Y	N
Weight loss	Y	N
Pain	Y	N
Insomnia	Y	N

Other _____

Allergy/Immunology

Rash	Y	N
Wheezing	Y	N

Other _____

Ophthalmologic

Change in vision	Y	N
Discharge	Y	N

Other _____

ENT

Decreased hearing	Y	N
Nosebleeds	Y	N
Painful swallowing	Y	N
Earaches	Y	N
Hoarseness	Y	N
Mass or lumps	Y	N

Other _____

Endocrine

Cold intolerance	Y	N
Heat intolerance	Y	N
Excessive thirst	Y	N
Excessive sweating	Y	N

Other _____

Respiratory

Cough	Y	N
Shortness of breath at rest	Y	N
Shortness of breath with exertion	Y	N
Wheezing	Y	N

Other _____

Cardiovascular

Chest pain at rest	Y	N
Chest pain with exertion	Y	N
Difficulty lying flat	Y	N
Irregular heartbeat	Y	N

Other _____

Gastrointestinal

Abdominal Pain	Y	N
Blood in stool	Y	N
Change in bowel habits	Y	N
Difficulty swallowing	Y	N
Heartburn	Y	N
Reflux	Y	N
Nausea	Y	N
Rectal bleeding	Y	N
Vomiting	Y	N
Constipation	Y	N
Diarrhea	Y	N

Other _____

Hematology

Easy bruising	Y	N
Easy bleeding	Y	N

Other _____

Genitourinary

Difficulty urinating	Y	N
Urinary frequency	Y	N
Painful urination	Y	N

Other _____

Musculoskeletal

Joint stiffness	Y	N
Painful joints	Y	N
Swollen joints	Y	N

Other _____

Peripheral Vascular

Cold extremities	Y	N
Decreased sensation in extremities	Y	N

Other _____

Skin

Mole(s)	Y	N
Nodule(s)	Y	N
Rash	Y	N
Skin Cancer	Y	N

Other _____

Neurological

Trouble with balance	Y	N
Gait abnormality	Y	N
Headache	Y	N
Seizures	Y	N
Numbness/Tingling	Y	N
Dizziness	Y	N
Lightheadedness	Y	N
Memory Changes	Y	N

Other _____

Psychological

Anxiety	Y	N
Depressed mood	Y	N
Difficulty sleeping	Y	N

Other _____

Cancer Related

Chemotherapy	Y	N
Radiation	Y	N

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Demographic/HIPAA Form

Name:_____
FIRST MI LAST

Home Phone:_____( ) Cell Phone:_____( ) Work Phone:_____( )

Home Address:_____
STREET APT # CITY STATE ZIP

DOB:_____ Age:_____ Sex:_____ Social Security #:_____

Emergency Contact Name:_____ **Relationship:**_____ **Phone:** ( )

Emergency Contact Name:_____ **Relationship:**_____ **Phone:** ( )

Is the patient a minor?	Yes	No	**Is the patient an adult dependent?**		Yes	No
Are you employed?	Yes	No	Full-Time	Part-Time	Self Employed	Retired
Are you a student?	Yes	No	Full-Time	Part-Time		
Marital Status:	Single	Married	Divorced	Widowed		

***Please tell us how you heard about our office:**
_____

Please provide information of your current medical providers beginning with the physician who referred you to us:

_____ _____ ( )
REFERRING PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

_____ _____ ( )
PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

_____ _____ ( )
PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARDS AND PHOTO I.D.

PRIMARY INSURED INFORMATION IF NOT THE PATIENT:

Name:_____ Relationship:_____
FIRST MI LAST

DOB:_____ Age:_____ Sex:_____ Social Security #:_____

Address:_____
STREET APT # CITY STATE ZIP

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION AND MEDICAL RECORDS / CONSENT TO TREATMENT / APPOINTMENT OF AUTHORIZED REPRESENTATIVE / NOTICE OF PRIVACY PRACTICES

***PLEASE INITIAL NEXT TO THE FOLOWING FOUR STATEMENTS**

_____ I hereby authorize payment directly to the physician of surgical and/or medical benefits, if any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____ I hereby authorize the physician to release any information and/or medical records acquired in the course of my treatment necessary for my treatment or to process insurance claims to doctors, nurses, or other medical personnel who are involved in my care.

_____ I hereby give my consent for medical treatment by the physician to myself or dependent.

_____ We are committed to securing the privacy of your health information. We are supplying you with our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ _____
SIGNATURE OF PATIENT OR LEAGALLY AUTHORIZED REPRESENTATIVE DATE

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
AND REVIEW OF
PATIENT RESTRICTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

I have received and reviewed North Texas Surgical Oncology Associates **Notice of Privacy Practices**, which explains how my Individually Identifiable Health Information (IIHI) may be used or disclosed. IIHI is the same as my medical information. I have also received a copy of this **Acknowledgment of Review and Patient Restriction of Protected Health Information**. I can fill in the names of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my IIHI. I understand that my Primary Care Physician will be provided access to my IIHI unless otherwise noted below.

I am confirming receipt of this Acknowledgment of Review of Privacy Practices and identifying who has access to my IIHI, other than myself. Please check below.

☐ I do not want anyone to have access to my IIHI. I am the only one who should have access to my IIHI.

☐ It is agreed and acceptable for my "spouse only" to have access to my IIHI.

☐ Patient is under eighteen (18) years of age and understands that his/her legal representative has access to his/her IIHI and the legal representative is signing below.

☐ I want the person/s listed below to have access to my IIHI:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ It is acceptable to leave a detailed, medical or billing information on a phone message for me at the following number:

(_____) _____ ☐ Home ☐ Work ☐ Cell

☐ It is agreed and acceptable for NTSOA to communicate with me by email and NTSOA's patient portal, below is the email I would prefer to use.

Email address: _____

☐ I agree to receive Fax communication from NTSOA if necessary, below is the fax number I prefer to use.

FAX: (_____) _____

_____
Printed Name of Patient OR Legally Authorized Representative

_____
Signature of Patient OR Legally Authorized Representative

Date _____

OFFICE USE ONLY

Dr. David L. Smith Dr. Thomas E. Le Voyer Dr. M. Umar Butt Dr. Fred S. Lee

_____
Signature of NTSOA Staff Member

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ACKNOWLEDGE OF RECIEPT OF PATIENT POLICIES AND INFORMATION GUIDE

By signing below I acknowledge receipt of the **Patient Policies and Informational Guide** which includes information on fees associated with no-shows, same-day cancellations and failed appointments as well as other subjects including: appointments, test results, telephone calls, refill requests, records requests, insurance, referrals, payment for services and emergencies.

_____
Printed Name of Patient OR Legally Authorized Representative

_____
Signature of Patient OR Legally Authorized Representative

Date _____

PHARMACY ASSIGNMENT AND AUTHORIZATION

The pharmacy I normally get my prescriptions from is:

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____
STREET CITY STATE ZIP

I authorize this office to have access to my prescription drug history.

PATIENT NAME PRINTED **DATE**

PATIENT SIGNATURE

This section of the form is optional.
We are required to ask the following questions in order to meet Federal electronic medical records requirements.

PRIMARY LANGUAGE: _____

ETHNICITY: _____
(GENETIC BACKGROUND)

RACE: _____
(CULTURAL ASSOCIATION)

NTSOA STAFF MEMBER INITIALS: _____

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SURGERY CANCELLATION POLICY

Scheduling of your surgery requires a coordinated effort of multiple people beginning with your doctor and including his nursing and administrative staff. Authorization by your insurance carrier must be obtained and scheduling of the facility and anesthesia. A tremendous amount of work takes place in preparation for your surgery.

Cancellation of surgery is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused surgery time. Potentially productive time by the physician goes unused despite the tremendous amount of work required in preparation for the particular surgery. Other patients who could have benefited from that surgery time cannot do so unless the surgery time is made available soon enough.

Therefore, a minimum of 72 business hours (3 business days) notification is required for surgery cancellation. This allows the physician and his staff to potentially fill the slot with another patient. Failure to notify us of cancellation in the required time will result in a charge of $150.00. This will be posted to your account.

Exceptions to this policy will be made only for emergencies and conflicts beyond our control.

By signing below you are acknowledging that you have read this policy and understand that a cancellation of your surgery may result in a fee of $150.00

Patient's Signature: _____ Date: _____

Printed Patient Name: _____

_____ By initialing here I am acknowledging the following:

There are three components of my surgery that may require payment from me.

- Surgeons Fee – paid to the surgeons office at the time of scheduling surgery
- Facility Fee – paid to the facility on the date of service
- Anesthesia Fee – paid to anesthesia (usually billed after surgery)

I understand that I am responsible for the $150.00 cancellation fee if I am unable to satisfy any of the above and decide to cancel my surgery during the three business days prior to my scheduled surgery date.

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Patient Policies and Informational Guide

Our mission is to provide excellence in medical care and personal service. We honor the doctor-patient relationship and encourage you to take an active role in your health.

Appointments
The office is open for appointments from 8:00am – 4:30pm, Monday through Friday; phones are answered until 4:30pm. We are closed for most major holidays. Same day appointments may be available, and we will make every effort to see you if you have an acute medical need during our regular business hours.

All patients must bring a current photo I.D., insurance cards (if any), and a list of medications to each appointment. This list should include prescriptions, over-the-counter medications and supplements. Please bring any film or CD of radiology reports, if any.

New patients please arrive 30 minutes prior to your appointment with your completed New Patient Packet. Established patients please arrive 15 minutes prior to your appointment to allow for check-in.
Please be on time so that you will be able to keep your appointment, late arrival of 15 minutes or more may result in the cancellation or rescheduling of your appointment.

Should you need to reschedule or cancel your appointment, please notify the office with at least 24 hours' notice, otherwise you will receive a reminder call the day before your appointment.

Keep in mind; we reserve your appointment time for you, therefore, no-shows, last minute cancellations, or late arrivals may result in a $25.00 cancellation fee assessed to your account. In order to protect the rights of other patients who are waiting to be scheduled, you may be asked to find another medical provider if you have two or more consecutive missed or cancelled appointments.

After each appointment your doctor or their Medical Assistant should hand you a clinic sheet, this will tell the staff what appointments, test, or lab work is needed for your next office visit. Remember to stop at the front desk to checkout before leaving the office they will take your clinic sheet and schedule your follow up appointment.

No-Show/Cancellation Policy
As a patient in our clinic, it is your responsibility to maintain your scheduled appointments. The clinic requires that all appointment cancellations be received 24 hours before the scheduled appointment. Failure to cancel the appointment with proper notice will result in a failed appointment fee of $25.00.

In order to continue to provide prompt attention to all of our scheduled patients, it is necessary to have a late arrival policy. The clinic will consider a "failed appointment" any time a patient has not given the advance notice required above or has failed to arrive within 15 minutes of their appointment time. If a patient arrives 15 or more minutes late, they may be asked to reschedule and the appointment will be considered a "late cancellation" and result in the assessment of a failed appointment fee.

Telephone Calls
Our telephone is answered 24 hours a day. Calls are initially answered by our receptionist. If you have a question or need to speak to the physician or medical staff please provide as much information as possible to the receptionist. He or she will forward your message to the appropriate person. Your call will be returned by the end of the business day. After hours, the on call physician will be available to handle urgent medical issues. Non-emergency calls, such as appointments, medications, and refills should be made between 8:00am and 4:30pm Monday-Friday.

Patient Portal
NTSOA's patient portal provides a way for you to communicate with our practice, securely and efficiently during our business hours. Using the patient portal will allow you to view your personal health records and update as needed, view your lab results, request appointments, request to change a scheduled appointment, or see date/time of upcoming appointments, and manage your personal information.
Emergencies

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If you have a true medical emergency, call 911 or go to the nearest Emergency Department. Ask them to contact our office at (972) 696-0030.

Test Results
The results of laboratory and radiology tests are very important for the continued evaluation and management of your care. Tests are performed by laboratories as determined by your health insurance. It may take several days to get these test results back to our office. When having radiology test, scans, biopsies or any other procedure done outside our office, please know that we will make every effort to obtain the results as soon as possible. However, it could take 48 hours to a week for those results to reach us.

Test results are given at your follow up appointment. **No diagnostic test or pathology results are given by phone.**

Requests for Refills
Please call your local pharmacy for medication refills, including those medications that have no remaining refills or requests for additional refills. Your pharmacy will contact us for refill authorization, if necessary.

Referrals and Pre-Certifications
Your insurance may require a referral from your physician in order for you to see a specialist. Your insurance may also require pre-certification of office or outpatient services. As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you. Some managed care contracts specify the location for these services. Our staff is trained to help our patients through this process and will answer any questions you may have.

Requests for Medical Records
Our office is happy to provide you with a copy of your medical records. If you are in need of a copy of your medical records or wish to have a copy sent to another physician please allow 15 business days for records request to be processed. A fee may be assessed for copies with payment required before records will be released. Records, FMLA, and Disability paperwork may be charged at $25.00 for the first 20 pages and $0.50 for each additional page.

Payment for Services
We recognize the need for a clear understanding between you and our office regarding payment for services. Charges for professional services and treatment depend upon the terms of your insurance contract. Co-payment and unmet annual deductibles are payable at the time of your visit this includes any payment required for scheduling surgical procedures. Patients without insurance coverage will be given a discount off the fee billed for paying at the time of service based on commercial insurance contracts average reimbursement for the services needed. We accept cash, check, Visa, Discover, MasterCard and American Express.

Insurance
Please notify us immediately if there are any changes in your coverage, employer or insurance company. When a change occurs, we will verify the new coverage and do our best to ensure a smooth transition.
Our front office staff is always available during regular office hours to answer any questions you may have.

Talking to Your Doctor
You may not remember everything you want to ask your doctor, and may find it helpful to write down questions prior to your appointment. When you do get answers to your questions, write them down, too. That way, when you go home, you won't forget and you will be better equipped to answer questions that your family may have. Keep track of how you are feeling and any changes you notice so you can inform your doctor. By staying organized, you are helping yourself remain in control of your illness.