PLEASE ARRIVE 30 MINUTES EARLY AND STOP AT THE REGISTRATION DESK ON THE FOURTH FLOOR PRIOR TO APPOINTMENT.

If your insurance requires a referral, please call your PCP prior to appointment. Our NPI number is 1841226099.

PLEASE BE ADVISED:

IF YOU CANCEL YOUR NEW PATIENT APPOINTMENT LESS THAN 24 HOURS BEFORE YOUR APPOINTMENT TIME, OR DO NOT COME TO THE APPOINTMENT AS SCHEDULED WITHOUT NOTIFYING OUR OFFICE, YOU MAY BE SUBJECT TO A CHARGE OF $ 75.00 DOLLARS.

Hematology/Oncology
Suite 440

CARDIOLOGY
John P. Fisher, M.D.
Leslie H. Poor, M.D.
Sean C. Curran, M.D.
Sheetal Chandhok, M.D.
Tarun Mathur, M.D.
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(610) 642-1090

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Margaret T. Ryan, M.D.
(610) 527-1604

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Molly S. Stumacher, M.D.
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Belinda K. Birnbaum, M.D.
(610) 525-4463

825 OLD LANCASTER ROAD SUITE 440
BRYN MAWR, PA 19010
Phone: 610-525-4511
Fax: 610-525-8561

NOTICE TO ALL HEMATOLOGY/ONCOLOGY PATIENTS

Payment for **ALL** treatments is expected at the time of service.

This includes balances due form **all high deductible** health insurance plans and/or plans that require **co-insurance**.

Payment may be made by check or credit card.

We appreciate your understanding and cooperation with this policy.

The Hematology/Oncology Department

DIRECTIONS

From 476 N:

Take 476 N to exit 13 (Villanova/St. Davids)

Make right on to Route #30 East

Follow Route 30 for approximately 1.7 miles

When you reach McDonald's (on left), make a right on to County Line Road

Continue on County Line Road to Bryn Mawr Avenue, make a left on to Bryn Mawr Avenue

Follow Bryn Mawr Avenue to the first traffic light (Old Lancaster Road), turn left on to Old Lancaster Road

Bryn Mawr Medical Specialists (825 Old Lancaster Road) is on the right (Medical Arts Pavilion)

Parking may be found in the parking garage across the street or with valet parking

From 476 S:

Take 476 S to exit 13 (Villanova/St. Davids)

Make a right on to Route 30 East

Follow directions above

From 76 E and W to 476 N and S follow directions above

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Bryn Mawr Medical Specialists ASSOCIATION

825 OLD LANCASTER ROAD SUITE 440
BRYN MAWR, PA 19010
Phone: 610-525-4511
Fax: 610-525-8561

The Hematology-Oncology team at Bryn Mawr Medical Specialists (BMMSA) is comprised of physicians who are board certified in Oncology, Hematology and Internal Medicine, oncology nurse specialists, lab and support staff. Our physicians care for patients with hematologic (blood) or oncologic (cancer) conditions. When necessary, our physicians admit patients to Bryn Mawr Hospital.

The Bryn Mawr Hospital and our practice provide a complete range of hematology and oncology services with a very “patient-oriented” philosophy.

Sandra F. Schnall, M.D. is a graduate of Tufts University and Jefferson Medical College. She completed a fellowship in both Hematology and Oncology at the Yale University Cancer Center in 1986 and most recently was an Associate Professor at Temple Cancer Center before coming to BMMSA in 1998.

John G. Devlin, M.D. is a graduate of St. Joseph’s University and Temple University School of Medicine. He completed his residency in Internal Medicine as well as a fellowship in both Hematology and Oncology at Temple University Hospital and Fox Chase Cancer Center. He joined BMMSA in July 2007.

Sameer Gupta, M.D., M.P.H. is a graduate of Maulana Azad Medical College and All India Institute of Medical Sciences in India, as well as the University of Alabama at Birmingham. He completed a residency in Internal Medicine at the State University of New York in Buffalo, and a fellowship in both Hematology and Medical Oncology at Temple University Hospital and Fox Chase Cancer Center. He is currently a Clinical Assistant Professor of Medicine at Jefferson Medical College. He joined BMMSA in 2011.

Molly S. Stumacher, M.D. is a graduate of Harvard University and Harvard Medical School. She completed her residence at Brigham and Women’s Hospital in Boston and a fellowship in both Hematology and Oncology at the University of Pennsylvania School of Medicine in Philadelphia. Prior to joining BMMSA, Dr. Stumacher practiced at Penn Hematology-Oncology of Chester County for 12 years. She joined BMMSA in July 2018.

BMMSA’s Hematology-Oncology physicians have contributed to the medical literature and are very active in clinical research. The Bryn Mawr Hospital Cancer Program provides care for over 1,000 newly diagnosed cancer patients annually, and it is affiliated with all major National Cancer Institute clinical research groups including the Eastern Cooperative Oncology Group (ECOG), National Surgical Adjuvant Breast and Bowel Project (NSABP), Radiation Therapy Oncology Group (RTOG), Gynecology Oncology Group (GOG), and with the clinical research program of the M.D. Anderson University of Texas Cancer Center.

Our office and treatment center is located in the Bryn Mawr Medial Arts Pavilion at 825 Old Lancaster Road, Suite 440, in Bryn Mawr (across from the Warden Lobby of the Bryn Mawr Hospital).

We may be reached by phone, day or night, at 610-525-4511. Our fax number is 610-525-8561. If you are a new patient, please complete the enclosed patient information form and bring it with you at the time of your initial consultation. We will obtain any pathology and radiology results from Bryn Mawr Hospital. However, we ask that you obtain relevant records, radiology and pathology reports and slides from any other hospitals and from other physicians and bring these with you at the time of your first visit (or have these faxed to us beforehand).

Relevant medical literature about your condition is available by brochure, pamphlet, etc. at our office.

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

Patient Registration Form

PLEASE PRINT CLEARLY Date _____ Account Number _____

PATIENT INFORMATION				
Patient's Last Name: First Name: Middle Initial:			Date of Birth:	Sex: ❑ Male (M) ❑ Female (F) Gender Identity: ❑ Transgender Male (FTM) ❑ Transgender Female (MTF) ❑ Genderqueer (G) ❑ Other (O)
Patient's Street Address:			Marital Status: ❑ S ❑ M ❑ D ❑ W	
City:	State, ZIP: (9 digit if known)	Patient's Home Phone #:		Patient's Cell Phone #:
Billing Street Address of Responsible Party (if different from above):		Race: ❑ African-American ❑ Asian ❑ Caucasian ❑ Other Ethnicity: ❑ Hispanic ❑ Non-Hispanic		
City:	State, ZIP:	Primary Language: ❑ English ❑ Other:_____		Email:
Employer's Name:		Work Phone #:		
Pharmacy Name, Address, and Telephone #:				
Referring Physician's Name and Telephone #:		Primary Care Physician's Name and Telephone #:		

INSURANCE INFORMATION			
Primary Insurance Company Name:			
Identification or Policy Number:	Group Number:	Insurance Company Phone #:	
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other		
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:	
Secondary Insurance Company Name:			
Identification Number:	Group Number:	Insurance Company Phone #:	
Name of Policyholder:	Patient's Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Partner ❑ Dependent ❑ Other		
Policyholder's Date of Birth:	Policyholder's Sex: ❑ Male ❑ Female	Effective Dates of Insurance:	

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Relationship To Patient: ❑ Spouse ❑ Partner ❑ Parent/Guardian ❑ Child ❑ Other	
Home Phone #:	Cell Phone #:	Work Phone #:

AUTHORIZATION AND RELEASE

* I authorize any holder of medical information about me to release this information to the Centers for Medicare and Medicaid Services, my insurance company or its intermediaries or carriers, or to this physician's office.

* I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Bryn Mawr Medical Specialists Association. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

* I understand that I am financially responsible for all charges whether or not paid by said insurance.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

Please hand this form and your insurance cards to the Receptionist.

REV 12/21

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BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
825 OLD LANCASTER ROAD
SUITE 320
BRYN MAWR, PENNSYLVANIA 19010

Financial Policy

We would like to take this opportunity to welcome you to our offices and assure you that we will do our utmost to provide you with the best possible care.

Patients with Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier. It is your responsibility to read and understand your insurance agreement; certain services may or may not be covered, depending on your individual policy. **Please provide current insurance information to the office, including any changes in coverage**. If your insurance requires a form, please provide one to the office. We will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for the payment of the bill.**

Portions of the bill may not be paid by the insurance company, and are to be paid by the patient. For example, a co-payment may be required by you as per your insurance agreement. If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our Business Office will gladly assist you in arranging a payment plan. If you are unable or unwilling to accept responsibility for your account balance, please be advised that your account may be forwarded to a collection agency, which will adversely affect your credit.

If you have a **High Deductible Health Plan (HDHP)**, please notify the office prior to your visit. If you have not met your deductible, we will bill you directly for any balance due. Please note, the office may request payment up front.

If you are covered through an **out-of-state insurance plan**, it is your responsibility to contact your carrier and determine if our physicians participate with your plan. Please note that these types of plans typically carry high out-of-pocket expenses.

Patients without Insurance Coverage

Patients without insurance coverage are requested to pay for services as rendered. We accept MasterCard and Visa payments.

I have read and understand the Financial Policy of Bryn Mawr Medical Specialists Association.

X_____ _____
Signature of Patient or Guardian **Date**

_____
Account Number

Revised: January 13, 2020

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION (BMMSA)

Patient Consent for Financial Responsibility for Treatment

Patient Name: _____

Account #: _____

Date: _____

Insurance Carrier: _____

Treatment: _____

Physician: _____

I understand that I have received a recommendation for treatment for my medical condition from my physician. I also understand that sometimes an insurer, including mine, may not pay for treatment, even when recommended by my physician. The physicians at BMMSA cannot predict with certainty whether my insurer will pay for this treatment. BMMSA may have a contact with my insurer that precludes BMMSA from billing and collecting payment from me for services that my insurer refuses to pay unless I agree beforehand that I will pay for such treatment. I hereby do agree to pay for the above therapy and related costs if my insurer will not.

Patients Signature: _____

Witness (Medical Assistant): _____

MEDICAL RECORDS RELEASE

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
HEMATOLOGY/ONCOLOGY
825 OLD LANCASTER ROAD, SUITE 440
BRYN MAWR, PA 19010
PHONE: (610) 525-4511
FAX: (610) 525-8561

SANDRA F. SCHNALL, M.D.
JOHN G. DEVLIN, M.D.
SAMEER GUPTA, M.D., M.P.H.
MOLLY S. STUMACHER, M.D.

PATIENT INFORMATION

NAME: _____

DOB: _____

ADDRESS: _____

_____

TELEPHONE:_____

SIGNATURE: _____

DATE: _____

I hereby request that my medical records be released to:

Bryn Mawr Medical Specialists Association
Hematology/Oncology
825 Old Lancaster Road, Suite 440
Bryn Mawr, PA 19010

Name:_____

Date: _____ DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

Welcome to the office of Drs. Schnall, Devlin, Gupta and Stumacher. In order that we may get to know you better, please complete this form and bring it with you to your visit.

What brings you to see the doctor?

_____
_____
_____
_____

Please list all of your physicians (including the physician who referred you to our office):

_____
_____
_____
_____

Please list all medications you are now taking (doses, tablet size, frequency, and approximately how long you have been on each, if possible):

_____
_____
_____
_____

Please list any medicines to which you are allergic, as well as the nature of the allergic reaction:

Medicine	Reaction

Are you allergic to intravenous dye (contrast) such as that given with CAT scans?
(circle one) Yes No

Describe your reaction to dye:

_____

Name: _____

PAST MEDICAL HISTORY

Please circle and describe below all of the following surgeries which you have had. Write the approximate year of surgery next to any circled answer.

Appendix	Prostate	Tonsils/Adenoids
Gallbladder	Hysterectomy	Oral Surgery
Kidney	Ovaries	Sinus Surgery
Stomach	Breast	Skin
Hernia	Thyroid	Broken Bones
Intestines	Eye/Cataracts	Artificial Joint
Heart	Hemorrhoid	Varicose Veins
Lung	Spine	Cancer Surgery

Neurosurgery (Brain, Spinal Cord)

Other Surgery:

_____

_____

_____

If you have been previously hospitalized, please complete:

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____

Please circle and describe below any of the following medical conditions you have had in your lifetime:

High Blood Pressure	Hepatitis	Pneumonia
Heart Attack	Gastrointestinal Disease	Emphysema
Heart failure	Angina	Hiatal Hernia
Bronchitis	Heart Murmur	Ulcer
Asthma	Leaky Heart Valve	Stomach Reflux
Pleurisy	Rheumatic Fever	Gallstones
Tuberculosis	Lyme Disease	Arthritis
Urine/Bladder Infection	Seizures	Anemia
Kidney Trouble	Nervous Disorder	Blood Transfusion
Kidney Stones	Blood Clots (Phlebitis)	Diabetes
Prostate Infection	Phlebitis	Thyroid Disease
Venereal Disease	Glaucoma	Blood Disorder
Cancer (Type:_____)	HIV	Stroke

Any other illness:

_____

_____

_____

Occupation: _____

Do you smoke? Yes_____ No _____

If yes, how much do you smoke in one day? _____

If no, in the past did you ever smoke regularly? _____

How much did you smoke? _____ When did you stop? _____

Do you drink alcohol? Yes _____ No _____
If yes, please estimate the amount consumed each day: _____
If no, did you ever drink alcohol regularly in the past? _____

Have you ever been exposed to asbestos? Yes _____ No _____
Where and when? _____

Have you ever used any hormone treatment (such as estrogen, etc.)?
Yes _____ No _____
When? _____ How long? _____

Place an (x) alongside any of the following symptoms you have noticed and describe below:

__ poor appetite
__ weight gain
__ weight loss
__ fever, chills
__ excess sweating
__ fatigue
__ trouble w vision
__ eye pain/redness
__ hearing trouble
__ ear pain/discharge
__ ringing of ears
__ nosebleeds
__ nasal discomfort
__ throat discomfort
__ voice change
__ dental/gum symp.
__ cough
__ sputum
__ chest pains
__ wheezing
__ heart "skipping"
__ short of breath
__ pain
__ lumps

__ swollen feet or ankles
__ leg pains
__ leg ulcers
__ varicose veins
__ jaundice
__ heartburn
__ weak urine stream
__ difficulty swallowing
__ special food intolerance
__ abdominal pain
__ nausea
__ vomiting
__vomiting blood
__ belching or flatulence
__ black stool/rectal bleeding
__ rectal discomfort
__ diarrhea
__ backache
__ arthritis/joint pain
__ "bursitis"
__ muscular aches
__ burning on urination
__ frequency of urination

__ nighttime urination
__ urgency of urination
__ difficulty starting urination
__ loss of control of urine
__ pus in urine
__ blood in urine
__ bruise/bleed easily
__ swollen glands
__ hot weather intolerance
__ cold weather intolerance
__ increased thirst
__ increased urine volume
__ skin problems
__ hair/nail problems
__ itching
__ headaches
__ dizziness
__ fainting
__ numbness, pins/needles
__ tremor
__ muscle weakness/paralysis
__ seizures, convulsions
__ faulty memory

__ nervousness
__ depression
__ trouble sleeping
__ work/family prbs
__ sexual problems

MEN:
__ prostate trouble
__ discharge from penis
__ painful/swollen testes
__ date of last prostate exam
Date of last prostate exam
_____
Was it normal? Yes __ No__
Date of last PSA_____

WOMEN:
__ trouble with menstruation
__ vaginal discharge
__ hot flashes
__ breast lump or discharge
Date of last period _____
Date of last mammogram __
Location of last mammogram
_____
Was it normal? Yes__ No__
Date of last Pap test _____
Dr. who performed Pap ____
_____

Please describe any other symptoms:
_____
_____
_____

Date of last rectal/Hemoccult (test for blood in stool) exam _____ Was it normal? Yes ___ No ____

Doctor who performed rectal/Hemoccult _____

Date of last Colonoscopy_____

Date of last Upper Endoscopy_____

Please fill in your family history:

RELATIVE	AGE IF LIVING	CAUSE OF DEATH IF DECEASED	AGE AT DEATH	MEDICAL PROBLEM
FATHER				
MOTHER				
SIBLINGS				
SPOUSE				
CHILDREN				

Please describe any cancer history in your family (or any other important family history not listed above):

Please include if you have had depression, alcohol, or drug difficulties or unusual anxiety:

An oncology social worker is available free of charge in our practice for individual/family counseling, coping with your diagnosis, insurance or employment issues, community resources and to work with children whose parents are going through cancer treatment.

___ Please check if you would like to be seen by the social worker.

___ Our practice has access to the latest clinical trials, which may pertain to your condition. Please check here if you would be interested in hearing about these clinical trials.

Is there anything else you think we should know?

Print: _____
Patient's Name

Under Federal Law, as of 4/15/03, your doctors (Dr. S. Schnall, J. Devlin, S. Gupta, and M. Stumacher) cannot discuss your medical condition with anyone other than yourself (except with other medical professionals, in furtherance of your medical care) without written release signed by you. Thus, your doctor cannot discuss your condition with your spouse, children, siblings, etc., without your written authorization.

Please list below any individuals with whom you give Drs. Schnall/Devlin/Gupta/Stumacher permission to discuss your condition and their relationship to you (i.e. spouse, children, etc.).

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Patient's signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices (revised 6/2020): Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices, which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgment and consent.

http://bmmsa.com/wp-content/uploads/2013/07/bmmsa-noticeofprivacy.pdf

If you would like to receive a copy of the Privacy Notice, please request one at the time of your appointment.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Mail: Bryn Mawr Medical Specialists Association
825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010
Attention: Russ Militello

Phone: (610) 527-3800, extension 3027

Acknowledgement & Consent

I have received the notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialists Association is authorized to use health information about _____(***Print Name***) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

_____

Signature of Patient or Representative Date of Birth Date Account #

Relationship to Patient (if applicable):_____

Release of Covered Information

Please **CIRCLE** your preferred phone number.

Home: _____ _____ Office may leave **message with detailed information.**

Mobile: _____ _____ Office may leave **message with callback number/name only.**

Email address: _____

I give permission to disclose personal health information to: (**please circle)**

Spouse Adult Children Parents Siblings Personal Representative

List names and phone numbers of above:

_____

NOTICE OF PRIVACY PRACTICES
BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

Effective Date: August 22, 2013

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

If you have any questions regarding this notice, you may contact our Privacy Officer at:

Address: Bryn Mawr Medical Specialists Association
Attention: Russ Militello
825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010

Telephone: (610) 527-3800, ext. 3027

Facsimile: (610) 527-0308

I. YOUR PROTECTED HEALTH INFORMATION

Bryn Mawr Medical Specialists Association is required by the federal privacy rule to maintain the privacy of your health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of the notice currently in effect. We are also required to notify you following a breach of your unsecured protected health information.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you.

Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care operations

This section describes how we may use and disclose your protected health information for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

Treatment

We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other personnel who are involved in your care at our office.
- We may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work, and x-rays.
- We may disclose medical information about you to people outside of our office who may be involved in your medical care, such as other physicians, family members, or other health care related entities, such as skilled nursing facilities with whom you seek treatment.
- We may use a patient sign-in sheet in the waiting area which is accessible to all patients.
- We may page patients in the waiting room when it is time for them to go to an examining room.
- We may contact you to provide appointment reminders.

Payment

We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether a proposed treatment is a covered service.
- We may need to give your health insurance company information about a procedure you received so you health insurance company will pay us or reimburse you for the procedure. This may include submission of a claim form.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.
- We may also disclose you medical information to other healthcare providers so that they can bill for health care services that they provided to you, such as ambulance services.
- Mailing you bills in envelopes with our practice name and return address.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing information to a collection agency or an attorney for purposes of securing payment of a delinquent account.

Health care operations

We may use and disclose your protected health information for our health care operation purposes, as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- We may use and disclose medical information about you for various quality assurance and quality improvement activities.
- Population-based activities relating to improving health or reducing health care costs.
- Conducting training programs for doctors, nurses, technicians, medical and nursing students, and other personnel.
- Health care fraud and abuse detection and compliance programs.
- Conducting other medical review, legal services, and auditing functions.
- Business planning and development activities, such as conducting cost management and planning-related analyses.
- Sharing information regarding patients with entities that are interested in purchasing our entity and turning over patient records to entities that have purchased our entity.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.
- Conducting fundraising activities. With any fundraising communication, you will be given the opportunity to opt out of future solicitations.

B. Other uses and disclosures not requiring authorization

We may use and disclose your protected health information for other purposes:

- Family members or close friends involved in your care or payment for your treatment.
- In a disaster relief effort so that your family can be notified of your condition and location.
- A government disaster relief agency if you are involved in a disaster relief effort.
- To inform you of treatment alternatives, or benefits or services related to your health. If we receive anything of value for making these communications, we will notify you of this fact, and you will have an opportunity to opt out of future communications.
- To contact you to raise funds for our entity. Information used and disclosed for fundraising will be limited to your name and other limited information permitted by law. You will have the opportunity to opt out of future fundraising communications.
- As required by law.
- Public health activities, including disease prevention, injury or disability, reporting of births and deaths, reporting child abuse or neglect, reporting reactions to medications or product problems, notification of recalls, infectious disease control, notifying government authorities of suspected abuse, neglect, or domestic violence (if you agree or as requited by law).

- Health oversight activities (e.g. audits, inspections, investigations, and licensure activities),
- Lawsuits and disputes (e.g. as required by court or administrative order, or in response to a subpoena or other legal process).
- Law enforcement (e.g. in response to legal process or as required or allowed by law).
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation organizations.
- Certain research projects, as approved by an Institutional Review Board, or if certain conditions are met.
- To prevent a serious threat to public health or safety.
- To military authorities if you are a member of the armed forces.
- National security and intelligence agencies.
- Protection of the President or other authorized persons or foreign heads of state, or to conduct special investigations.
- Inmates or others in custody of a correctional institution or law enforcement.
- Workers' Compensation (in compliance with applicable laws).
- To Business Associates (individuals or entities that perform functions on our behalf, e.g. to install a new computer system, provided they agree to safeguard the information).
- We may incidentally disclose protected health information as a byproduct of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.
- We may disclose proof of immunization to a school for admission with oral or written agreement from a parent/guardian, or other person acting in *loco parentis*, or directly from the individual if an adult or emancipated minor.

C. Uses and disclosures with authorization

All other purposes that do not fall under a category listed above will require your written authorization to use or disclose your protected health information. We will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes, without a signed authorization. You may revoke your authorization, and thereby stop any future uses and disclosures, by notifying us in writing.

III. PATIENT PRIVACY RIGHTS

You have the following rights regarding your medical records. Please contact our Privacy Officer to exercise your rights.

A. Right to request restriction

You may request limitations on how we use or disclose your medical information for health care treatment, payment, or operations (e.g. you may ask us not to disclose that you have had a particular surgery). We are not required to agree with your request, except for requests to restrict disclosures to a health plan for purposes of payment or health care operations when you have paid in full out-of-pocket for the item covered by the request, and when the disclosure is not requited by law. If we agree, we will comply with your request, unless the information is needed to provide you with emergency treatment.

B. Right to confidential communications

You may request communications in a certain way or at a certain location. For example, you might request that we only contact you by mail or at work. We will accommodate reasonable requests for confidential communications, but you must specify how or where you wish to be contacted, and how payment will be handled.

C. Right to accounting of disclosures

You may request a list of instances where we have disclosed your medical information for certain types of disclosures. The accounting will not include disclosures that we are not required to record, such as disclosures pursuant to an authorization. This right is limited to disclosures within 6 years of the request. The first accounting you request within a 12-month period is free, but we will charge a fee for any additional lists requested within the same 12-month period.

D. Right to inspect and copy

You have a right to look at and obtain a copy of your medical records, billing records, and other records used to make decisions about your care. We may charge you a fee for our postage and labor costs and supplies to create a copy. Under limited circumstances, your request may be denied and you may request a review of the denial by another licensed health care professional of our choosing. We will comply with the outcome of the review. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.

E. Right to request amendment

If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your records be amended. Under limited circumstances, we may deny your request for amendment. If denied, you will receive an explanation for the decision and information explaining your options.

F. Right to copy of privacy notice

You may request a paper copy of this Notice at any time by contacting our Privacy Officer. You may also obtain an electronic copy of this Notice on our website. The Notice will be provided to you in other formats if you require special accommodations by contacting our Privacy Officer.

G. Right to notification of breach

We are required by law to notify affected individuals following a breach of unsecured medical information. A breach is generally defined as any disclosure of unsecured protected health information not permitted by this Notice. Examples of exceptions include unintentional access by employees and inadvertent disclosures within an office.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any new provisions effective for all protected health information that we maintain at the time of change, including information that we created or received prior to the effective date of the change. We will post a copy of our current Notice in our waiting room and also on our website. At any time, patients may review the current notice or request a paper copy by contacting our Privacy Officer.

V. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer, or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for filing a complaint.*

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices (revised 6/2020): Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices, which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgment and consent.

http://bmmsa.com/wp-content/uploads/2013/07/bmmsa-noticeofprivacy.pdf

If you would like to receive a copy of the Privacy Notice, please request one at the time of your appointment.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

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825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010
Attention: Russ Militello

Phone: (610) 527-3800, extension 3027

Acknowledgement & Consent

I have received the notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialists Association is authorized to use health information about _____(***Print Name***) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

_____

Signature of Patient or Representative Date of Birth Date Account #

Relationship to Patient (if applicable):_____

Release of Covered Information

Please **CIRCLE** your preferred phone number.

Home: _____ _____ Office may leave **message with detailed information.**

Mobile: _____ _____ Office may leave **message with callback number/name only.**

Email address: _____

I give permission to disclose personal health information to: (**please circle)**

Spouse Adult Children Parents Siblings Personal Representative

List names and phone numbers of above:

_____

MEDICAL RECORDS RELEASE

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
HEMATOLOGY/ONCOLOGY
825 OLD LANCASTER ROAD, SUITE 440
BRYN MAWR, PA 19010
PHONE: (610) 525-4511
FAX: (610) 525-8561

SANDRA F. SCHNALL, M.D.
JOHN G. DEVLIN, M.D.
SAMEER GUPTA, M.D., M.P.H.
MOLLY S. STUMACHER, M.D.

PATIENT INFORMATION

NAME: _____

DOB: _____

ADDRESS: _____

_____

TELEPHONE:_____

SIGNATURE: _____

DATE: _____

I hereby request that my medical records be released to:

Bryn Mawr Medical Specialists Association
Hematology/Oncology
825 Old Lancaster Road, Suite 440
Bryn Mawr, PA 19010

Print: _____
Patient's Name

Under Federal Law, as of 4/15/03, your doctors (Dr. S. Schnall, J. Devlin, S. Gupta, and M. Stumacher) cannot discuss your medical condition with anyone other than yourself (except with other medical professionals, in furtherance of your medical care) without written release signed by you. Thus, your doctor cannot discuss your condition with your spouse, children, siblings, etc., without your written authorization.

Please list below any individuals with whom you give Drs. Schnall/Devlin/Gupta/Stumacher permission to discuss your condition and their relationship to you (i.e. spouse, children, etc.).

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Patient's signature Date

Name:_____

Date: _____ DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

Welcome to the office of Drs. Schnall, Devlin, Gupta and Stumacher. In order that we may get to know you better, please complete this form and bring it with you to your visit.

What brings you to see the doctor?

_____
_____
_____
_____

Please list all of your physicians (including the physician who referred you to our office):

_____
_____
_____
_____

Please list all medications you are now taking (doses, tablet size, frequency, and approximately how long you have been on each, if possible):

_____
_____
_____
_____

Please list any medicines to which you are allergic, as well as the nature of the allergic reaction:

Medicine	Reaction

Are you allergic to intravenous dye (contrast) such as that given with CAT scans?
(circle one) Yes No

Describe your reaction to dye:

_____

Name: _____

PAST MEDICAL HISTORY

Please circle and describe below all of the following surgeries which you have had. Write the approximate year of surgery next to any circled answer.

Appendix	Prostate	Tonsils/Adenoids
Gallbladder	Hysterectomy	Oral Surgery
Kidney	Ovaries	Sinus Surgery
Stomach	Breast	Skin
Hernia	Thyroid	Broken Bones
Intestines	Eye/Cataracts	Artificial Joint
Heart	Hemorrhoid	Varicose Veins
Lung	Spine	Cancer Surgery

Neurosurgery (Brain, Spinal Cord)

Other Surgery:

_____

_____

_____

If you have been previously hospitalized, please complete:

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____

Please circle and describe below any of the following medical conditions you have had in your lifetime:

High Blood Pressure	Hepatitis	Pneumonia
Heart Attack	Gastrointestinal Disease	Emphysema
Heart failure	Angina	Hiatal Hernia
Bronchitis	Heart Murmur	Ulcer
Asthma	Leaky Heart Valve	Stomach Reflux
Pleurisy	Rheumatic Fever	Gallstones
Tuberculosis	Lyme Disease	Arthritis
Urine/Bladder Infection	Seizures	Anemia
Kidney Trouble	Nervous Disorder	Blood Transfusion
Kidney Stones	Blood Clots (Phlebitis)	Diabetes
Prostate Infection	Phlebitis	Thyroid Disease
Venereal Disease	Glaucoma	Blood Disorder
Cancer (Type:_____)	HIV	Stroke

Any other illness:

_____

_____

_____

Occupation: _____

Do you smoke? Yes_____ No _____

If yes, how much do you smoke in one day? _____

If no, in the past did you ever smoke regularly? _____

How much did you smoke? _____ When did you stop? _____

Do you drink alcohol? Yes _____ No _____
If yes, please estimate the amount consumed each day: _____
If no, did you ever drink alcohol regularly in the past? _____

Have you ever been exposed to asbestos? Yes _____ No _____
Where and when? _____

Have you ever used any hormone treatment (such as estrogen, etc.)?
Yes _____ No _____
When? _____ How long? _____

Place an (x) alongside any of the following symptoms you have noticed and describe below:

__ poor appetite
__ weight gain
__ weight loss
__ fever, chills
__ excess sweating
__ fatigue
__ trouble w vision
__ eye pain/redness
__ hearing trouble
__ ear pain/discharge
__ ringing of ears
__ nosebleeds
__ nasal discomfort
__ throat discomfort
__ voice change
__ dental/gum symp.
__ cough
__ sputum
__ chest pains
__ wheezing
__ heart "skipping"
__ short of breath
__ pain
__ lumps

__ swollen feet or ankles
__ leg pains
__ leg ulcers
__ varicose veins
__ jaundice
__ heartburn
__ weak urine stream
__ difficulty swallowing
__ special food intolerance
__ abdominal pain
__ nausea
__ vomiting
__vomiting blood
__ belching or flatulence
__ black stool/rectal bleeding
__ rectal discomfort
__ diarrhea
__ backache
__ arthritis/joint pain
__ "bursitis"
__ muscular aches
__ burning on urination
__ frequency of urination

__ nighttime urination
__ urgency of urination
__ difficulty starting urination
__ loss of control of urine
__ pus in urine
__ blood in urine
__ bruise/bleed easily
__ swollen glands
__ hot weather intolerance
__ cold weather intolerance
__ increased thirst
__ increased urine volume
__ skin problems
__ hair/nail problems
__ itching
__ headaches
__ dizziness
__ fainting
__ numbness, pins/needles
__ tremor
__ muscle weakness/paralysis
__ seizures, convulsions
__ faulty memory

__ nervousness
__ depression
__ trouble sleeping
__ work/family prbs
__ sexual problems

MEN:
__ prostate trouble
__ discharge from penis
__ painful/swollen testes
__ date of last prostate exam
Date of last prostate exam
_____
Was it normal? Yes __ No__
Date of last PSA_____

WOMEN:
__ trouble with menstruation
__ vaginal discharge
__ hot flashes
__ breast lump or discharge
Date of last period _____
Date of last mammogram __
Location of last mammogram
_____
Was it normal? Yes__ No__
Date of last Pap test _____
Dr. who performed Pap ____
_____

Please describe any other symptoms:
_____
_____
_____

Date of last rectal/Hemoccult (test for blood in stool) exam _____ Was it normal? Yes ___ No ____

Doctor who performed rectal/Hemoccult _____

Date of last Colonoscopy_____

Date of last Upper Endoscopy_____

Please fill in your family history:

RELATIVE	AGE IF LIVING	CAUSE OF DEATH IF DECEASED	AGE AT DEATH	MEDICAL PROBLEM
FATHER				
MOTHER				
SIBLINGS				
SPOUSE				
CHILDREN				

Please describe any cancer history in your family (or any other important family history not listed above):

Please include if you have had depression, alcohol, or drug difficulties or unusual anxiety:

An oncology social worker is available free of charge in our practice for individual/family counseling, coping with your diagnosis, insurance or employment issues, community resources and to work with children whose parents are going through cancer treatment.

___ Please check if you would like to be seen by the social worker.

___ Our practice has access to the latest clinical trials, which may pertain to your condition. Please check here if you would be interested in hearing about these clinical trials.

Is there anything else you think we should know?