



Welcome to Shenandoah Oncology and thank you for choosing us as your Oncology and Hematology provider. Our primary goal is to provide quality medical care which is easily accessible and responsive in your time of need. Whether you are seeing us for Oncology (cancer) or benign Hematology (non-cancer blood) concerns, our staff includes a comprehensive interdisciplinary team of medical and administrative professionals who will strive to exceed your expectations. We aim to ensure your experience with us is as comfortable and as stress free as possible.

At Shenandoah Oncology, we take a team approach to healthcare delivery. Each team consists of a board-certified hematologist oncologist, an office-based nurse practitioner, a dedicated inpatient nurse practitioner, a clinical medical assistant, and a dedicated scheduler. Additionally, we have a licensed social worker on staff who can help guide you through your emotional, social, and family concerns. If needed, you will also be assigned a nurse in our treatment room who specializes in the treatment and care of oncology and hematology patients.

Depending on your diagnosis, you will see either the doctor or office-based nurse practitioner at your first visit. Together, they will develop a plan of care for you that will best meet your individual needs. Your team will also assist in coordinating care with other providers, specialists and community resources as needed.

Enclosed you will find an appointment card with your provider's name, visit date and time. Again, thank you for choosing Shenandoah Oncology.

# SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW

## PATIENT HISTORY FORM

**Patient Name:**

Last

First

M.I.

Today's Date

Referred By

DOB

Marital Status

Height

Weight

**HISTORY OF PRESENT ILLNESS:** Please describe the problem for which you are referred today.

**PAST HISTORY:** If you need additional space, it is provided on the last page.

**Surgeries (with dates)**

**Medical Conditions**

**Blood Transfusion History:**

☐ Yes ☐ No

If yes, when?

**Reproductive History:**

Number of pregnancies

Number of children:

Age at first pregnancy:

Age at first period

Age at last period:

Are you pregnant now

☐ Y ☐ N

Hysterectomy:

☐ Y ☐ N

Ovaries removed

☐ Y ☐ N

Hormone use:

☐ Y ☐ N

Oral contraceptive use

☐ Y ☐ N

**Preventive Health Maintenance:** Please provide dates for each answer or write "none"

**Circle One: Male OR Female**

Last mammogram:

Last Prostate exam:

Last Pap smear:

Last PSA screening:

Last colonoscopy:

Last Flu vaccine:

Last bone density scan:

Last pneumonia vaccine:

**SOCIAL HISTORY**

**Substance**

**Do you use?**

**What Type?**

**How Much?**

**How Often?**

**If quit, when?**

Alcohol:

☐ Y ☐ N

Tobacco:

☐ Y ☐ N

Caffeine:

☐ Y ☐ N

Recreational Drugs:

☐ Y ☐ N

**FAMILY HISTORY:** Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Brothers:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Father:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Sisters:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
				Children:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

## REVIEW OF SYSTEMS

Constitutional		Breast		Skin	
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Mass	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor Energy Level	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nodules	<input type="checkbox"/> Y <input type="checkbox"/> N
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Nipple Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Itchiness	<input type="checkbox"/> Y <input type="checkbox"/> N
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Size	<input type="checkbox"/> Y <input type="checkbox"/> N	Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Shape	<input type="checkbox"/> Y <input type="checkbox"/> N		
Eyes		Gastrointestinal		Neurological	
Double Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Confusion	<input type="checkbox"/> Y <input type="checkbox"/> N
Vision Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Flashing Lights	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N
		Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
		Maroon/Black Stool	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Change	<input type="checkbox"/> Y <input type="checkbox"/> N
		Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N	Headache	<input type="checkbox"/> Y <input type="checkbox"/> N
		Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Gait	<input type="checkbox"/> Y <input type="checkbox"/> N
		Vomiting Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
		Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensory Change	<input type="checkbox"/> Y <input type="checkbox"/> N
ENT/Mouth		Urinary		Psychiatric	
Ringing in Ears	<input type="checkbox"/> Y <input type="checkbox"/> N	Painful Urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in Urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Oral Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	Increased Frequency	<input type="checkbox"/> Y <input type="checkbox"/> N		
Mouth Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Control	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sore Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	Impotence	<input type="checkbox"/> Y <input type="checkbox"/> N		
Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N				
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N				
Cardiovascular		Gynecological		Endocrine	
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Urine	<input type="checkbox"/> Y <input type="checkbox"/> N
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Pelvic Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot Flashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Leg Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N			Heat/Cold Intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N
Arm Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N				
Respiratory		Musculoskeletal		Hematological	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscle Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nose Bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Spine Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Coughing Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Redness	<input type="checkbox"/> Y <input type="checkbox"/> N		
Pain with Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone Pain	<input type="checkbox"/> Y <input type="checkbox"/> N		
				Lymphatic	
				Enlarged Lymph Nodes	<input type="checkbox"/> Y <input type="checkbox"/> N
				Swelling in Arms/Legs	<input type="checkbox"/> Y <input type="checkbox"/> N

**Radiation/Chemo History:**Previous Radiation Therapy: ☐ Yes ☐ No

If yes, where? \_\_\_\_\_

Previous Chemotherapy: ☐ Yes ☐ No

If yes, where? \_\_\_\_\_

**Patient Preferences:**Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? ☐ Yes ☐ NoDo you have a durable power of attorney or a living will? ☐ Yes ☐ NoDo you have a current Advanced Directive? ☐ Yes ☐ No

If Yes, please bring a copy in for our records.

If No, please let us know if you would like to make an appointment with a Nurse Practitioner to complete your advance directives.

Are there any language barriers that the staff needs to be aware of? ☐ Yes ☐ NoDo you feel unsafe or threatened by anyone? ☐ Yes ☐ NoDo you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No**REFERRING PHYSICIANS:** Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PHARMACY:** Please list your pharmacy information.

Pharmacy	Address	Phone Number
_____	_____	_____

Are you a veteran? Yes or No ☐ Yes ☐ No If yes, which branch of military did you serve and in what years did you serve? \_\_\_\_\_Have you ever accessed the VA for any services? Yes or No ☐ Yes ☐ No If so, what services did you use? \_\_\_\_\_Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No ☐ Yes ☐ No**ADDITIONAL NOTES:** Please use this space to complete any additional notes that were not completed above.

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Patient Signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Current Medication Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

## Allergies & Adverse Reactions

Medication	Reaction

## Current Medications

## Prescription, over-the-counter, and herbal remedies

[illegible]

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_



## Acknowledgment of Receipt of Notice of Privacy Practices

Shenandoah Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shenandoah Oncology, P.C.

Printed Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Representative (if appropriate):  
\_\_\_\_\_

Signature of Representative (if appropriate):  
\_\_\_\_\_

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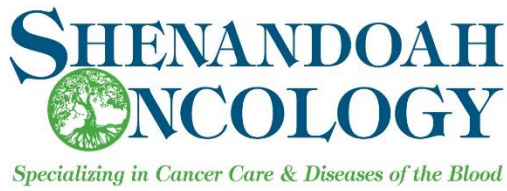
### Shenandoah Oncology, P.C. Use Only

Date acknowledgement received: \_\_\_\_\_

**OR**

Reason acknowledgement was not obtained and employee signature:  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_



AUTHORIZATION FOR RELEASE OF  
RECORDS TO  
SHENANDOAH ONCOLOGY, P.C.

Medical Records Phone: 540-450-0682

Medical Records Fax: 540-667-3408

Date: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to release information from the records of:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number

I authorize that the following records may be sent:

- ☐ Physician notes/letters
- ☐ Hospital Records
- ☐ Treatment Records
- ☐ Laboratory and Pathology results
- ☐ Pathology slides & tissue blocks
- ☐ Radiology reports and disks
- ☐ All of the above

This authorization will expire in twelve months following the date of signature, unless otherwise specified below.

Expiration Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Authorization of Release of Medical Information

Date: \_\_\_\_\_

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient

You may release this information to the following individuals:

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number





## User Electronic Mail Authorization Form

### Patient Portal: My Care Plus

The Patient Portal, My Care Plus, offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire within 7 days. If you should change email addresses, please contact your physician's office in order to provide your new email information so that you will continue to receive updates and other pertinent information about your record. Please choose an email address (**one email address per patient**) that will not be subject to access by anyone you do not trust. Please ensure the email address you provide is not a duplicate email address in use by another patient here at Shenandoah Oncology.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

You are receiving access to the Portal; the terms and conditions of the Portal shall apply to this User Electronic mail Authorization Form. **Please write legibly.**

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Email Address (Print legibly)

Authorized user is:

☐ Patient

☐ Patient's Designee

\_\_\_\_\_  
Patient's Designee's Name (Printed)

\_\_\_\_\_  
Patient's Designee's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

MRN		For Office Use Only – Staff Initials		Date	
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ATTENTION: If you speak Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindu, German, or Bengali, language assistance services, free of charge, are available to you. Call Front Office Supervisor at 540-662-1108

Atención: Si usted habla español, Coreano, vietnamita, Chino, Árabe, neerlandés, persa, amárico, Urdu, Francés, Ruso, hindú, alemán o bengalí, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llame al Supervisor de recepción en 540-662-1108

주의: 만약 당신이 말하는 스페인어, 한국어, 베트남어, 중국어, 아랍어, 타갈로그어, 페르시아어, Amhric, Urda, 프랑스어, 러시아어, 힌두교, 독일어, Dengali, 또는 크루, 언어 지원 서비스, 무료로, 당신이 사용할 수 있습니다. 티파니 Front Office Supervisor tai 540-662-1108에서 호출

Chú ý: Nếu bạn nói tiếng Tây Ban Nha, Hàn Quốc, Việt Nam, Trung Quốc, tiếng Ả Rập, tiếng Tagalog, tiếng Ba tư, tiếng Amhara, tiếng Urdu, Pháp, Nga, Hindu, Đức hoặc tiếng Bengali, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi cho văn phòng mặt trận giám sát viên tại 540-662-1108

注意:如果您讲西班牙语、韩语、越南语、中文、阿拉伯语、塔加禄语、波斯语、阿姆法语、乌尔都语、法语、俄语、印度语、德语或孟加拉语,您可以免费获得语言协助服务。致电前台主管 540-662-1108

تنبيه: إذا كنت أتكلم الإسبانية الكورية، الفيتنامية، الصينية، العربية، التغالوغي، الفارسي، الأمهرية، الأردنية، الفرنسية، الروسية، الهندوسية، أو الألمانية أو البنغالية، خدمات المساعدة اللغوية، مجاناً، تتوفر لك. استدعاء المشرف على مكتب الجبهة في 540-662-1108

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Front Office Supervisor (540) 662-1108

ትኩረት: እናንተ ስንገኛ መናገር ከሆነ, ኮሪያኛ, ቪትናምኛ, ቻይንኛ, አረብኛ, ታጋሎግ, የፋርስ, አማርኛ, Urda, ፈረንሳይኛ, ሩሲያኛ, የሂንዱ, ጀርመንኛ, ቤንጋሊ, ወይም Kru, የቋንቋ እርዳታ አገልግሎቶች, ከክፍያ ነፃ, ለእርስዎ የሚገኙ ናቸው. 540-662-1108 ላይ ተፋኒ Front Office Supervisor ይደውሉ

توجه: اگر اسپانیایی کره ای، ویتنامی، چینی، عربی، تاگالوگی، فارس، امهری، اردو، فرانسوی، روسی، هندو، آلمانی یا بنگالی حرف زبان خدمات امداد، رایگان، به شما در دسترس هستند. سرپرست دفتر جلو در 540-662-1108 تماس بگیرید

ATTENTION : Si vous parlez espagnol, coréen, vietnamien, chinois, arabe, Tagalog, persan, amharique, ourdou, Français, russe, hindou, allemand, Bengali ou Kru, services d'assistance linguistique, gratuites, sont à votre disposition. Front Office Supervisor appel à 540-662-1108

ВНИМАНИЕ: Если вы говорите, испанский, корейский, вьетнамский, китайский, арабский, тагальский, Персидский, Турецкий, урду, французский, Русский, индуистской, немецкий, бенгальский или КРУ, языковых служб помощи, бесплатно, доступны для вас. Бريدن Front Office Supervisor звонка в 540-662-1108

ध्यान: यदि आप स्पेनिश, कोरियाई, वियतनामी, चीनी, अरबी, तागालोग, फारसी, Amharic, उर्दू, फ्रेंच, रूसी, हिंदू, जर्मन, या बंगाली, भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, आप के लिए उपलब्ध हैं। 540-662-1108 पर फ्रंट कार्यालय पर्यवेक्षक कॉल करें

Achtung: Wenn Sie Spanisch, Koreanisch, Vietnamesisch, Chinesisch, Arabisch, Tagalog, Persisch, Amharisch, Urdu, Französisch, Russisch, Hindu, Deutsch oder Bengali sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie Front-Office Supervisor bei 540-662-1108

দৃষ্টি আকর্ষণ: স্প্যানিশ, কোরিয়ান, ভিয়েতনামি, চাইনিজ, আরবি, ট্যাগালোগ, পারস্য, আমহারিক, উর্দু, ফরাসি, রুশ, হিন্দু জার্মান বা বাংলা কথা বলে। তবে ভাষা সহায়তা, ফ্রি, তোমার কাছে পাওয়া যায়। ফ্রন্ট অফিসের পরিদর্শক 540-662-1108 এ কল



## Erin Stuller, LCSW

Erin comes to Shenandoah Oncology, PC with more than 15 years of experience in the medical field. She worked as an LPN for ten years prior to pursuing a Master of Social Work degree from West Virginia University with a focus in clinical practice. Since graduation from WVU, Erin has provided psychotherapy services in primary care and behavioral health settings. At Shenandoah Oncology, PC, Erin can offer supportive counseling to patients and family members struggling to cope with a cancer diagnosis and the subsequent challenges that may arise. Benefits of her services include improved emotional and mental well-being, assistance accessing available resources, and opportunity for reflection. Erin is also available for coordination of care and Advanced Care Planning needs.

- Provides psychosocial support including counseling, information, and resources
- Promotes coordination of care
- Assists with financial guidance (in coordination with the patient financial counselors)
- Offers connections to community resources for transportation, housing and/or expenses
- Facilitates Advance Care Planning discussions
- Guides end of life discussions and hospice referral assistance





Nicholas W. Gemma, M.D. Richard M. Ingram, M.D. • William A. Houck, III, M.D. • Lee P. Resta, M.D. Lindsey M. O'Brien, M.D. • M. Page Jones, M.D. Rodney Huff, MSN, FNP-BC • Jonathan Hanson, MSN, FNP-BC Risa Barton, MSN, FNP-BC • Kim Applegate, MSN, FNP-BC Laurie Hudson, MSN, FNP-BC • Kendra Atherton, FNP-BC  
540-662-1108 Fax: 540-667-3408

## CONSENT TO TELEMEDICINE

By signing this document, you have agreed to receive care using telemedicine. Telemedicine enables health care providers at a different location than yourself to provide safe, effective, and convenient care using technology. There are risks associated with the use of telemedicine, including equipment failure and information security issues. You also understand that we cannot physically examine you.

We at Shenandoah Oncology often prefer face-to-face visits with our patients, however, sometimes the use of telemedicine is safer and more convenient; for example, in the event of an illness, COVID-19, inclement weather, etc.

By signing this document, you agree that you have access to a smart device with video and audio capabilities (such as a tablet, desktop computer, or smartphone) for the telemedicine visit.

Our providers are licensed in Virginia, so by signing this you are agreeing to accurately report your location for the telemedicine visit, which must be in Virginia.

By signing this you endorse understanding the potential risks of telehealth to include, but not limited to, distortion of images resulting from electronic transmission issues, delays in evaluations/treatments due technical difficulties or interruptions, unauthorized access to my information, or loss of information due to technical failures. I will not hold Shenandoah Oncology accountable for such issues or sequelae.

I also endorse understanding that my providers rely on the information provided by me in our telemedicine visit and that I must provide updated/accurate information about my current and past medical history.

If you are determined to be eligible for a telehealth visit, you will be provided information on how to log on to the platform. The use of this platform helps to protect your health information.

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Signature of patient or representative

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Date

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Printed name of patient or representative

## **Telehealth FAQs**

### **What is telehealth?**

- Telehealth is a way to visit with a healthcare provider using technology.
- You can talk to your provider from any place, including your home.

### **How do I use telehealth?**

- You talk to your provider by phone, computer, or tablet.
- You use video so you and your provider can see each other.

### **How does telehealth help me?**

- You don't have to go to a clinic to see your provider.
- You won't risk getting sick from other people.

### **Can telehealth be bad for me?**

- You and your provider won't be in the same room, so it may feel different.
- You will not have a full physical exam during a telehealth visit.
- Your provider may decide you still need an office visit in person in our office.
- Technical problems may interrupt or stop your visit before you are done (see consent for additional risks).

### **Will my telehealth visit be private?**

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

- There is a very small chance that someone could use technology to hear or see your telehealth visit.

#### **How much does a telehealth visit cost?**

- What you pay depends on your insurance, but a telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.