PHOENIX CYBERKNIFE & RADIATION ONCOLOGY CENTER

Welcome,

Thank you for choosing Phoenix Cyberknife and Radiation Oncology.

In an effort to make your initial visit both pleasant and efficient, we have several patient information forms to be completed before your appointment. This information will be used to prepare your medical chart.

Please complete these forms and bring them with you 30 minutes prior to your appointment, or you may fax or mail the completed forms to our office prior to your appointment. When you arrive, we will photocopy your insurance card and driver's license. If you have a copy of your medical records and or radiology scans on CD, you are welcome to mail, fax or bring them by our office, as our providers like to review your history 1 to 2 days prior to your appointment.

If your insurance company requires a referral or authorization number for you to see a specialist, please contact your primary care physician for the necessary referral or authorization number. Any co-payments for the initial consultation are payable at the time of service. We accept cash, check or credit cards.

A nurse will be seeing you prior to your visit with the physician. At that time she will go over your medications and medical history, so please bring your medications and a list of any physicians currently involved in your care.

If you have any questions or need assistance, please feel free to call our office between 7:30am and 4:30pm, Monday through Friday.

On behalf of Phoenix Cyberknife and Radiation Oncology, we look forward to meeting you and helping you with your medical needs.

Sincerely,

Your Phoenix Cyberknife and Radiation Oncology Team

Phone 602-441-3845
Fax 602-464-9769

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

Patient Name: Date of Birth:

By signing below I give permission for the institution listed to disclose my protected health information to Phoenix Cyberknife and Radiation Oncology Center:

Person/Institution: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

This protected health information is being used or disclosed for the following purpose: Medical consultation, follow-up appointment, and/or treatment

Information to be disclosed **Dates (if known):** ____________________

- ☐ Most Recent History and physical
- ☐ Discharge summary
- ☐ Initial consultation note
- ☐ Most Recent progress note
- ☐ All radiology reports and imaging discs or dates specified: ____________
- ☐ All Operative reports or dates specified: ____________
- ☐ All Pathology reports or dates Specified: ____________
- ☐ Most recent laboratory results
- ☐ Chemotherapy records
- ☐ Radiation therapy records: Initial Consult, treatment summaries, treatment plans, plan images.
- ☐ Other______________________________

Date by which the information is needed: ______________________________

Send Records to:
4611 E SHEA BLVD, SUITE 120
PHOENIX, AZ 85028
P: 602-441-3845
F: 602-464-9769

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

You may revoke this authorization in writing at any time by sending written notification to Phoenix Cyberknife and Radiation Oncology Center, 4611 E. Shea Blvd, Ste 120, Phoenix, AZ 85028. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

This agreement will expire one year from the date of signature unless cancelled by the patient/guardian.

______________________________ ____________________
Signature of Patient Date

______________________________ ____________________
Legal Guardian / Patient Representative / Relationship to patient Date

PATIENT PERSONAL INFORMATION

Name : DOB: Sex:

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other ____________________ Preferred Language: ______________________________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unwilling to Provide ☐ Unknown
Address:
Email Address:____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership
Social Security #:

Employer ____ Occupation _____________________
Street Address: ____
City: ____State: __________________ Zip: ______________

RESPONSIBLE PARTY INFORMATION ☐ Same as Above
Responsible Party ____ DOB _____/_______/______
Relationship to Patient ☐ Self ☐ Spouse ☐ Other _____________________ SSN _______-_______-________
Street Address ____ Apt #__________
City ________________________________ State ________ Zip _________________
Home Phone (__________) _________-____________ Cell Phone (__________) __________-____________
Work Phone (_________) __________-___________
Employer ____ Occupation __________________

PATIENT INSURANCE INFORMATION Please present insurance card at check-in
Name of Insured ____

Primary Insurance Company ____
Patient relationship to Insured ☐ Self ☐ Spouse ☐ Other ______________________
Insurance ID ____________________________ Group # _______________________

Secondary Insurance Company ____
Patient relationship to Insured ☐ Self ☐ Spouse ☐ Other ______________________
Insurance ID ____________________________ Group # _______________________

EMERGENCY CONTACT

Name ____ Relationship _________________________
Home Phone: ________________ Cell Phone: _______________ Work Phone: _______________
Are we able to discuss your medical information with your emergency contact: ☐Yes ☐No

I have received a copy of the Privacy Rules from this practice

Signature: ____Date: _________________________

How were you referred you to our office?

Please check one:

☐Previous patient of our office: ________________________________ ☐Facebook/LinkedIn ☐Insurance Provider
☐Friend/Family ☐Sonoran Living ☐Phoenix Magazine ☐PCROC Website ☐ Google Search

☐Physician (Name): ____________________________________ ☐ Other ________________________

PHYSICIAN LIST

Name : DOB:

To help us ensure continuity of care, please provide us with the following list of all doctors involved in your care. If at any time, you add, change or drop a physician please let our office know so that we may continue to keep the proper doctors informed. Thank You.

Specialty: ____Name: ____

Phone#: _______________________________Address:____

____

Specialty: ____Name: ____

Phone#: _______________________________Address:____

____

Specialty: ____Name: ____

Phone#: _______________________________Address:____

____

Name of Pharmacy: ____ Phone # (___________) ___________________________

Location: Major Cross Road ____

REVIEW OF SYSTEMS WORKSHEET

Name : DOB: Age:

Brief Explanation for Today's Visit:

____

____

Past Medical History:

Have you had radiation treatment in the past? ☐Yes ☐No

If yes, to what part of body? ____

When: ______/______/_____ Facility: ____________________________________

Have you had chemotherapy in the past? ☐Yes ☐No

When: ______/______/______ Facility: ____________________________________

Are you currently undergoing chemotherapy? ☐Yes ☐No

Date of last dose: ______/______/______ Facility: ____________________________

Any previous surgeries: ☐Yes ☐No

Type: ____________________ Date: ____________ Facility: ____________________

____

____

____

Implanted Devices: Do you have any implanted or metal devices? ☐Yes ☐No

☐Venous Access Device/Type__________________ ☐Pacemaker ☐Aneurysm Clip

☐Screws, pins, plates/Where? __________________ ☐Stent ☐Other ______________

Do you have? ☐ Diabetes ☐Thyroid Problems ☐Other:

____

____

____

Smoking History:

Have you ever smoked? ☐Yes ☐No (If yes, please answer the following questions)

Do you currently smoke? ☐Yes ☐ No # of Packs per Day: _________ Number of years: _________

If you have quit smoking: When: _____/_____/______

Alcohol Consumption:

Do you consume alcohol? ☐Yes ☐No

If yes: How often? ________________________ How much? _____________________

Controlled Substance Usage:

Do you currently use controlled substances? ☐Yes ☐No

If yes: What substance? __________________________ How often? ___________________ How much? ___________________

Gynecological: (Females Only)

# of Children: _____ # of Pregnancies: _____ # of live births: ______ Other: ____________

How old were you when your 1st child was born? _____________

Did you breastfeed? ☐ Yes ☐ No How Long? ______________

Age at 1st Menstrual Period: _______ Last Menstrual Period: _____/______/______

Last Pelvic Exam/PAP: _____/______/_____

Hormones: ☐Yes ☐No Name: ____________________ How Long? _____________
Hysterectomy: ☐Yes ☐No When: _____/_____/_____ Why? ______________________________
Do you do self breast exams? ☐Yes ☐No How often? ________________________
Type of birth control currently used: __________________________
Date of last mammogram: _____/_____/_____ Facility: ______________________________________

Family History:
Is there any family history of cancer? ☐Yes ☐No (If yes; Who? And what type of cancer?)
____
____
____

Allergies:
☐ None
☐ Latex Reaction: __________________
☐ Medications: Drug: ________________________ Reaction: ______________________________
Drug: ________________________ Reaction: ______________________________
Drug: ________________________ Reaction: ______________________________

Weight: _______lbs Height: _____ft_____in

Please provide us with a list of current medications:

Medication	Dosage	Frequency	Purpose of Medication

If you need more space, please use reverse side

Review of Systems: (please check all that apply to your health)

General:
Please rate your level of fatigue 0-10 (0=none, 10=severe): _________
Are you now experiencing pain? ☐Yes ☐No If so, where? _________________________
Please rate your pain level 0-10 (0=none, 10=severe): _________
Do you experience any of the following?
☐ Fever ☐Chills ☐Night Sweats ☐Sleep Problems
Please explain: ____

Skin:
☐ No problems
☐Rashes ☐Itching ☐Skin Cancers ☐Burn easily in sun ☐Other____

Heart:
☐ No Problems
☐ Blood Pressure Problems ☐ Bruising/Bleeding ☐Palpitations
☐Swollen Ankles ☐Heart Attack/when? ___/___/___ ☐Other__________________________________

Neurological:
☐ No Problems
☐ Memory Loss/Forgetfulness □ Fainting Spells/Dizziness □ Visual Complaints □Claustrophobia
☐ Seizures/Convulsions □ Headaches/Migraine History □ Hearing Complaints □ Stroke
☐Other _______________________________________

Respiratory:
☐ No Problems ☐Received Flu Vaccine: Month/Year: ___________
☐ Shortness of Breath: ☐At Rest ☐With Activity
☐Home Oxygen (LPM_____) ☐Hoarseness ☐Breathing Medications ☐Asthma ☐Other: ____________________
Do you have a cough? ☐Yes ☐ No If yes, does it produce: ☐Blood or ☐Phlegm?

Skeletal/Muscular:
☐ No Problems
☐Arthritis ☐Numbness/Tingling ☐Weakness/Balance Problems ☐Back/Neck Pain
☐Blood Clots: Where? ______________________________________
☐Collagen Vascular Disease (i.e. Lupus, Scleroderma, etc.)

Digestive:
Appetite: ☐Good ☐Fair ☐Poor
Weight Loss: Have you lost weight in the last 6 months? ☐ Yes ☐No If yes, How much?:____________
☐No Problems
☐ Nausea/Vomiting ☐Heartburn/Reflux ☐Ulcers/Hiatal Hernia ☐Swallowing Problems
☐ Sores in Mouth ☐Chewing Problems ☐ Dentures
☐Other____
Do you follow a special diet? (If so, please explain) ____

Date of last Colonoscopy: ____

Urinary
☐ No Problems
☐ Burning ☐ Frequent ☐ Discomfort ☐Catheter ☐Ostomy ☐Urinary Tract Infections
☐ Incontinence (unable to hold bladder) ☐Other____

Bowel
☐ No Problems
☐ Diarrhea ☐Constipation ☐Stool Incontinence (loss of control) ☐Ostomy
☐Liver Disease/Hepatitis ☐Other____
Last BM:______________ Frequency of BM: _________________

If you have further information, which you feel would allow us to provide you with better care, or have special needs that must be addressed, please write it in the space below.

Patients Name: Date of Birth:

Please Initial next to each section:

_______ I hereby agree to pay for services rendered when charges are incurred, unless previous arrangements have been made. In the event of default, I agree to pay any collections costs and/or attorney fees as may be required to effect collection of charges incurred.

_______ I understand I will be receiving a bill from both RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER separately and authorize both entities to bill my insurance company for charges related to my treatment.

_______ I hereby authorize RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER to release any information acquired in the course of my examination or treatment. I also authorize photocopies of this form and my signature to be valid as the original.

_______ I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER.

_______ I hereby authorize payment directly to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance. I also guarantee that all the information I have provided is current and correct, and I understand that I am responsible for financial loss due to inaccurate/outdated information I provide.

_______ I will notify RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER. Immediately with any insurance, address or contact information changes. Otherwise I will be held responsible for all actions incurred by inaccurate/outdated information.

_______ If eligibility of insurance cannot be verified, or if deductible, out of pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered and payable to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and/or PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER.

_______ I request that payment of authorized Medicare, Medicare HMO and all other plans benefits be made either to me or on my behalf to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and/or PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER for any services furnished to me by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

________ I understand if I arrive after my appointment time there may be a significant wait as the clinic tries to work me into the schedule. I understand I may not be able to be seen and will be rescheduled as those who arrived on time will have priority over me.

I hereby authorize photocopies of this authorization and my signature to be as valid as the original.

PATIENT SIGNATURE: ____ DATE_________________
SIGNATURE OF SPOUSE/GUARANTOR:____ DATE__________________

Patient Name: ___________________________________
Date of Birth: _________________
Home # _________________ Cell # _________________

HIPAA Acknowledgement

I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name: ____________________________ Date of Birth: _______________________
Home #: ___________________________ Cell #: _____________________________
Relationship to patient: Spouse ☐ Parent ☐ Significant Other ☐ Other ________________

Name: ____________________________ Date of Birth: _______________________
Home #: ___________________________ Cell #: _____________________________
Relationship to patient: Spouse☐ Parent ☐ Significant Other ☐ Other ________________

Name: ____________________________ Date of Birth: _______________________
Home #: ___________________________ Cell #: _____________________________
Relationship to patient: Spouse ☐ Parent ☐ Significant Other☐ Other__________________

Name: ____________________________ Date of Birth: _______________________
Home #: ___________________________ Cell #: _____________________________
Relationship to patient: Spouse ☐ Parent ☐ Significant Other ☐ Other ________________

Name: ____________________________ Date of Birth: _______________________
Home #: ___________________________ Cell #: _____________________________
Relationship to patient: Spouse☐ Parent☐ Significant Other ☐ Other ________________

May we leave a detailed message regarding office visits and/or test results on your answering machine, home or cell? YES ☐ NO ☐

Signed: __________________________________ Date: ______________
(Patient or parent/legal guardian if patient is a minor)

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Phoenix Cyberknife and Radiation Oncology LLC is dedicated to protect your "nonpublic personal health information." This is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card and driver's license. This ensures you that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain the information from the hospital. However, on your first visit to this office we will ask you to fill out our information sheet to insure that the information we received from the hospital was correct.

We may also ask a doctor or other healthcare provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION?

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your records only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

IF you leave this practice, your Protected Health Information will continue to receive the protection outlined in this notice.

COMPLAINTS/COMMENTS: If you have any complaints concerning our privacy practices, you may contact the privacy officer of this practice at 602-441-3845.

This Practice reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to our policy will be posted in our office. This notice is effective as of February 21, 2013.