Mojave Radiation Oncology Center

Patient Registration

Name: ______________________ Date of Birth: ____________ Age: ______

Address: ____
Street City State Zip

SS#: ________________ Male _____ Female _____ Marital Status: (Circle) S M D W
Optional

Home Phone: ____________________ Mobile Phone: ____________________

Name of referring doctor: ____________________ Phone: ____________________

Name of Primary Care Doctor: ____________________ Phone: ____________________

Attention: We will use the address above and all numbers and address listed to contact you, mail copy of office visit notes and/or leave messages, and speak to friends or family involved in your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.

Are you a patient in a skilled nursing home? Yes _____ No _____ If yes, where: ____________________

Employed: Yes _____ No _____ Employer Name: ____________________ Occupation: ____________

Race: ☐American Indian or Alaskan Native ☐Asian ☐ Black or African American ☐White

☐Native Hawaiian or other Pacific Islander ☐Decline to Answer

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Spoken Language: ____________________ Preferred Language: ____________________

Emergency Contact: ____________________ Relation: ____________ Phone: ____________

Guarantor Name: ______________________________ Phone: ____________
Person Responsible for payment if other than patient

Primary Insurance Information

Name of Insurance: ____________________ Subscriber: ____________________ DOB: ____________

Member ID#: ____________________ Group#: ____________ Effective Date: ____________

Secondary Insurance Information

Name of Insurance: ____________________ Subscriber: ____________________ DOB: ____________

Member ID#: ____________________ Group#: ____________ Effective Date: ____________

______________________________ ____________________
Signature of Patient or Representative Date

New 2/2016

Mojave Radiation Oncology

MEDICATION LOG

PLEASE LIST ALL MEDICATION

Patient Name:______________________________ **Date of Birth:**_________________________

Date:____________________________________

Medication Name	Dose	Frequency

MOJAVE RADIATION ONCOLOGY CANCER CARE CENTER

Name: ______________________________ Date: ____________________

DO YOU HAVE ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

Good general health lately	Yes	No
Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

EYES

Eye disease or injury	Yes	No
Wear glasses / contact lenses	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	Yes	No
Ear aches or drainage	Yes	No
Chronic sinus problems/rhinitis	Yes	No
Nose Bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath or bad taste	Yes	No
Sore throat or voice change	Yes	No
Swollen glands in neck	Yes	No

CARDIOVASCULAR

Heart trouble	Yes	No
Chest pain or angina or pectoris	Yes	No
Palpitation	Yes	No
Shortness of breath	Yes	No
Swelling of feet, ankles or hands	Yes	No

RESPIRATORY

Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No

GASTROINTESTINAL

Loss of appitite	Yes	No
Change in bowel movements	Yes	No
Nausea or vomiting	Yes	No
Frequent diarrhea	Yes	No
Rectal bleeding	Yes	No
Abdominal pain	Yes	No
Peptic ulcer	Yes	No

GENITOURINARY

Frequent unination	Yes	No
Blood in urine	Yes	No
Sexual difficulty	Yes	No
Male - testical pain	Yes	No
Female - irregular cycle	Yes	No

Female - Pregnancies_________ Miscarriage_________

Last Pap____________ LMP____________

MUSCULOSKELETAL

Joint pain	Yes	No
Joint stiffness or swelling	Yes	No
Weakness of muscles or joints	Yes	No
Muscle pain or cramps	Yes	No
Back pain	Yes	No
Difficulty in walking	Yes	No

INTEGUMENTARY (skin, breast)

Rash or itching	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Breast pain	Yes	No
Breast lumps or discharge	Yes	No

NEUROLOGICAL

Frequent headaches	Yes	No
Dizziness	Yes	No
Convulsions or seizures	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head injury	Yes	No

PSYCHIATRIC

Memory Loss or confusion	Yes	No
Thyroid disease	Yes	No
Diabetes	Yes	No
Excessive thirst or urination	Yes	No
Recent dryness in skin	Yes	No

HEMOTOLOGIC/LYMPHATIC

Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Enlarged glands	Yes	No
Any transfusions	Yes	No

ALLERGIC/IMMUNOLOGIC

HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO:

Penicillan, antibiotics	Yes	No
Morphene, Demerol, Narcotics	Yes	No
Novacaine, anesthetics	Yes	No
Aspirin or pain remedies	Yes	No
Tetnus antitoxin or other serums	Yes	No
Iodine, methiolate, antiseptic	Yes	No

Other drugs/medications ______________________________

____

Known Food Allergies ______________________________

____

Patient Signature: ______________________________ Date of Birth: ____________________

New 2/2016

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

I authorize ___________________________ to release my medical records to the following individual or entity:

Name: MOJAVE RADIATION ONCOLOGY MED GRP 760-242-9999 760-242-1121 fax

Address: 18280 SISKIYOU RD APPLE VALLEY CA, 92307

This authorization for release of information covers the period of healthcare:

From: ______________ To ________________ *OR* all past, present, and future periods.
Date Date

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment ☐ Other (please specify): ____________________

The purpose of this release: ____

This medical information may used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effective for 90 days from the date of my signature below.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

________________________________ ______________ ______________
Signature of patient or personal representative Patient date of birth Todays Date

________________________________ ______________________
Printed name of patient or personal representative Relationship to the patient

Mojave Radiation Oncology Cancer Care Center

Welcome to Mojave Oncology Cancer Care Center! To ensure the highest level of patient satisfaction and comfort as well as efficiency on our behalf, the following protocol will be followed on your initial visit to our facility. Please acknowledge that these steps are devised with the patient in mind so that we may provide you with highest level of treatment and service. Thank you.

- Upon immediate arrival to the center, the patient is asked to check in with the front receptionist. He/She will give the patient all necessary information and consent forms that are required before treatment and consultation may occur.
- After forms have been completed by the patient, an employee or the Physician will lead the patient into a private exam room. The Physician will complete his initial consultation in this room. This procedure may include, but not limited to, a physical exam, oral questionnaire and/or discussion.
- Depending on the result of the initial consultation, a course of treatment will be decided between the Physician and the patient. Once treatment has been decided, consent forms must once again be completed. These forms will typically consent photographs of the patient, medical release forms and consent to the medical treatment.
- If applicable, the patient will be taken into a treatment room to plan their treatment. During this time, please be aware that the therapist, therapist technician, physicist and physician will all be entering your treatment room to design a treatment plan specifically for the individual patient. The process is crucial to your treatment.

The initial appointment will take a minimum of one and a half hours. Once again, please keep in mind that this process has been designed to benefit the patient and their well-being.

Print Name ____________________ Date of Birth ____________

Signature ____________________ Date ____________

New 2/2016

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Alqaisi (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

Patient/Guardian Signature: ______________________________ Date: ______________

Medi-gap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medi-gap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medi-gap insurer listed below any information needed to determine benefits payable for services from the Provider. This assignment is effective until evoked by me in writing.

Medi-gap Insurance Name: ____

Patient/Guardian Signature: ______________________________ Date: ______________

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: ______________________________ Date: ______________

Receipt of Notice of HIPAA Privacy Practices

I have received the Mojave Radiation Oncology Center's Notice of Privacy Practice from the Provider.

Print Name: ____DOB:______________

Patient/Guardian Signature: ______________________________ Date: ______________

New 2/2016

The American Cancer Society is here to help.

We have programs and services in your community to help people with cancer and their families. We offer information, day-to-day help, and emotional support. And our help is free. Listed below are a few examples of what the American Cancer Society offers. To learn more about our programs and services, call us toll-free, 24 hours a day, seven days a week, at 1-800-227-2345 or visit us online at cancer.org.

Help Getting to and from Cancer Treatment
Road To Recovery®

Every day, thousands of cancer patients need a ride to treatment, but some may not have a way to get there. If finding a ride is a problem for you, we may be able to help. Our Road To Recovery program provides free rides to and from treatment for people with cancer who do not have a ride or are unable to drive themselves. Volunteer drivers donate their time and the use of their cars so that patients can receive the lifesaving treatments they need.

Breast Cancer Support
Reach To Recovery®

Our Reach To Recovery program lets you talk one-on-one with a trained volunteer about breast cancer diagnosis and treatment. The volunteers are breast cancer survivors, so they know the questions and concerns that come with a diagnosis.

Interactive Online Classes
I Can Cope®   cancer.org/onlineclasses

Classes provide a quick and convenient way for patients and caregivers to get the answers they need, when they need them. Classes are self-paced and topics include pain, fatigue, nutrition, communication, intimacy, side effects and more.

Help with Lodging During Cancer Treatment

If you need treatment somewhere far from home, we may be able to help you find a free or reduced-cost place to stay near your treatment center.

Information and Resources
1.800.227.2345

Cancer Information Specialists provide the latest science-based cancer information and referrals through our 24-hour, multi-lingual, toll-free number. The Society's Web site provides the latest science-based cancer information, Clinical Trials Matching, event information and more at cancer.org.

Help with Appearance-Related Effects of Cancer Treatment
Look Good Feel Better®

Look Good Feel Better is a free program that teaches people in active cancer treatment ways to help them with appearance-related side effects. This program is offered jointly by the American Cancer Society, the Personal Care Products Council Foundation, and the Personal Beauty Association.

An Online Community of Cancer Survivors and Caregivers
Cancer Survivors Network℠   csn.cancer.org

The Cancer Survivors Network is a free online community created by and for people with cancer and their families. This online community is a welcoming, safe place for people to find hope and inspiration from others who have "been there." Services include discussion boards, chat rooms, and personal Web space to tell your story, blog, post images, exchange private messages with members, and much more.

cancer.org   1.800.227.2345   THE OFFICIAL SPONSOR OF BIRTHDAYS.™

Facility Name: Mojave Radiation Oncology Center
Facility City: Apple Valley, California 92307
Siebel ID# 1-1BDKOOH
Date Submitted ____________________

American Cancer Society Patient Referral Form

Fax to: ~~1-877-428-2862~~ 405-782-1363

If immediate assistance is needed, we are available 24 hours a day/7 days a week.
Please call 1-800-227-2345 or visit our Web site at www.cancer.org. All information and services are FREE.

Please check all requested services: *(if no services are checked, general information will be mailed)*

- ☐ Cancer information and organizer by mail (*please fill in Type of Cancer below*)
- ☐ A call to discuss Information and Support Services
- ☐ A call to discuss Transportation Assistance
- ☐ Other (please specify) ____________________

** Required information*

*** Patient Name:** Birth Date:

*** Daytime Phone:** ( ) *** OK To Leave Telephone Message?** ☐ Yes ☐ No

*** Address:**

*** City:** *** State:** *** Zip:**

Type of Cancer: Diagnosis Date:

Type of Insurance: ☐ Personal ☐ Medi-Cal ☐ Medicare ☐ Military/VA
**check all that apply* ☐ Employer-provided ☐ No Insurance ☐ Prefer not to answer

Primary Language: Race/Ethnicity: Sex: ☐ M ☐ F

Email Address: Preferred Method of Contact:

Contact Name (if other than patient): Phone: ( )
Relationship to patient: Contact instead of Patient? ☐ Yes ☐ No

The American Cancer Society (ACS) cares about your privacy and protects how we use your information. By signing this form you agree to let ACS receive and use your information to connect you to programs and services that may be of help in your care. Based on your needs, ACS may also share your information with others to help in your care (e.g., to provide transportation or lodging). You understand that you may be contacted in the future by ACS staff and volunteers about ACS programs, services and activities. For more information or to view ACS' full privacy policy, visit www.cancer.org or call 1-800-227-2345

Patient/Guardian Signature: Date:

Referred by: Mojave Radiation Oncology Phone: (760) 242-9999

Comments:

PLEASE FAX THIS FORM OR CALL:

Telephone: 1-800-227-2345 **Fax:** 405-782-1363

The information contained in this facsimile message is confidential. It is intended for the use of the American Cancer Society. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is strictly prohibited. Please fax to the American Cancer Society at the above number. Thank you for your cooperation.

Your Health Information Privacy Rights

Privacy is important to all of us

Other privacy rights

You may have other health information rights under your state's laws. When these laws affect how your health information can be used or shared, that should be made clear in the notice you receive.

For more information

This is a brief summary of your rights and protections under the federal health information privacy law. You can ask your provider or health insurer questions about how your health information is used or shared and about your rights. You also can learn more, including how to file a complaint with the U.S. Government, at the website at www.hhs.gov/ocr/hipaa/.

Published by:

U.S. Department of Health & Human Services Office for Civil Rights

Providers and health insurers who are required to follow this law must comply with your right to...

Get a report on when and why your health information was shared

Under the law, your health information may be used and shared for particular reasons, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or making required reports to the police, such as reporting gunshot wounds. In many cases, you can ask for and get a list of who your health information has been shared with for these reasons.

- You can get this report for free once a year.
- In most cases you should get the report within 60 days, but it can take an extra 30 days if you are given a reason.

Ask to be reached somewhere other than home

You can make reasonable requests to be contacted at different places or in a different way. For example, you can have the nurse call you at your office instead of your home, or send mail to you in an envelope instead of on a postcard. If sending information to you at home might put you in danger, your health insurer must talk, call, or write to you where you ask and in the way you ask, if the request is reasonable.

Ask that your information not be shared

You can ask your provider or health insurer not to share your health information with certain people, groups, or companies. For example, if you go to a clinic, you could ask the doctor not to share your medical record with other doctors or nurses in the clinic. However, they do not have to agree to do what you ask.

File complaints

If you believe your information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with your provider or health insurer. The privacy notice you receive from them will tell you who to talk to and how to file a complaint. You can also file a complaint with U.S. Government.