Welcome

Thank you for choosing Arizona Radiation Therapy Specialists.

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 Arizona Radiation Therapy Specialist, we look forward to meeting you and helping you with your medical needs.

Sincerely,

Your Arizona Radiation Therapy Specialist Team

ARIZONA Radiation Therapy *Specialists*

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 Arizona Radiation therapy Specialist:
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:

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 Arizona Radiation Therapy Specialist, 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

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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.

OTHERS NOT LISTED

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Name of Pharmacy: _____ Phone # (_____) _____

Location: Major Cross Road _____

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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.

_____

_____

_____

_____

_____

_____

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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 AZ DIGESTIVE HEALTH and authorize both entities to bill my insurance company for charges related to my treatment.

_____ I hereby authorize AZ DIGESTIVE HEALTH 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 AZ DIGESTIVE HEALTH.

_____ I hereby authorize payment directly to AZ DIGESTIVE HEALTH 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 AZ DIGESTIVE HEALTH 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 AZ DIGESTIVE HEALTH

_____ I request that payment of authorized Medicare, Medicare HMO and all other plans benefits be made either to me or on my behalf to AZ DIGESTIVE HEALTH 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 Acknowledgement
Appointment Cancellation Policy

Dear Patient,

Arizona Radiation Therapy Specialist has instituted an Appointment Cancellation Policy. A cancellation made with less than 24-hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office with 24-hour notice if you need to reschedule your appointment. This will allow us the opportunity to provide care for another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2. A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be assessed a $50 fee.
3. This fee is not billable to your insurance.
4. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
5. As a courtesy, we make reminder calls for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
6. Repeated missed appointments or No-Shows (3 Consecutive) may result in termination of the physician/patient relationship. A $50.00 Fee will be charged prior to making your next appointment, if you do decide to come back and be seen in our office.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

_____

Printed Name of Patient Signature of Patient Date

*******Copy given to patient******

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 Arizona Radiation Therapy Specialist 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.