COMPREHENSIVE
CANCER CENTERS

INTAKE SHEET
MRN: _____

Patient's Name: _____ **DOB:** _____ **Date:** _____
Reason for Appointment: _____ **Allergies:** _____

Past History:
____Childhood diseases ____Rheumatic Fever
____Diabetes ____TB
____Other _____

Previous Surgeries:

Date	Type
_____	_____
_____	_____
_____	_____

Family History:
Mother ☐ Living ☐ Dead ____ age
Father ☐ Living ☐ Dead ____ age
Sister ☐ Living ☐ Dead ____ age
Brother ☐ Living ☐ Dead ____ age
*Any family members with a history of:
_____Cancer _____Diabetes _____TB _____Heart Disease

Cause of Death:
_____
_____
_____
_____

Social History:
Married _____ Single _____ Divorced _____ Widowed _____
Occupation: _____
Spouse's Name: _____
Children: # Males _____ Ages _____ : # Females _____ Ages _____

Smoker: Yes _____ No _____ **Alcohol Intake:** Yes _____ No _____ How much? _____
How much? _____
How long? _____ Quit? _____

Current Medications:

Name:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems

Y	N			Y	N				Y	N	
____	____	Headaches		____	____	JT/Back Pain			____	____	Menopause
____	____	Visual Problems		____	____	Fevers				*Age: _____	
____	____	Lung Problems		____	____	Abdominal Pain			____	____	Chills
	*Date: _____			____	____	Jaundice			____	____	NOC Sweats
____	____	SOB		____	____	Gallstones			____	____	Unusual Swelling
____	____	Heart Problems		____	____	Nausea				Other medication problems	
	*Date: _____			____	____	Vomiting				_____	
____	____	Chest Pain		____	____	Diarrhea				_____	
____	____	Palpitations								_____	
____	____	Gastrointestinal		____	____	Urinary Problems					
	*Date: _____					*Frequency ____ Urgency ____ Nocturia ____ Dysuria ____					

Vital Signs: Temperature _____ BP _____ Pulse _____ Respiration _____ Height _____ Weight _____

Previous Chemo Tx: _____ ***ADVANCED DIRECTIVE** _____YES _____NO

Previous Radiation Tx: _____

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cccnevada.com

PATIENT ACKNOWLEDGEMENT

The undersigned patient of Comprehensive Cancer Centers of Nevada ("CCCN") acknowledges and agrees as follows:

1. My CCCN practitioner may refer me to non-CCCN healthcare providers for services including but not limited to diagnostic testing, imaging, and/or specialist consultation (each an "Outside Provider");

2. Outside Providers are not affiliated with CCCN, and CCCN has no control over their services;

3. CCCN is not responsible for any delays in my care or other disruptions to my diagnosis or treatment which may be caused by Outside Providers beyond CCCN's control; and

4. CCCN is not responsible for the costs of any services provided by Outside Providers, which may or may not be covered in whole or in part by my insurance plan.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

FOR CCCN USE ONLY:

Witness Signature: _____ Date: _____

Witness Name: _____ Title: _____

COMPREHENSIVE
CANCER CENTERS

DATE: _____

I hereby authorize:

Doctor's Name/ Facility Name: _____
Tel #: _____
Fax: _____

To release any and all medical records to:

COMPREHENSIVE CANCER CENTERS
7445 PEAK DR.
LAS VEGAS, NEVADA 89128
Tel: 702.952.2140; Fax: 702.952.2147 or 952.2180 ****SECURED FAX****

Patient Name: _____ DOB: _____

Patient's Signature: _____ Tel #: _____

PLEASE RELEASE THE FOLLOWING:

__ Treatment Plan/ Problem List Sheets
__ HISTORY & PHYSICAL
__ PATHOLOGY
__ ER, PR & DNA STUDIES
__DIAGNOSTIC TESTS
__ ALL RECENT LABS
__ LAST PROGRESS NOTES

OTHER

_____
_____
_____
_____
_____

Thank you.

COMPREHENSIVE
CANCER CENTERS

Electronic Prescriptions

Comprehensive Cancer Centers of Nevada uses electronic prescriptions to manager your medications.

By utilizing this system, we can automatically send your prescriptions to your pharmacy. You no longer need to take a paper prescription to your pharmacy for non-narcotic medications.

Certain prescriptions cannot be sent electronically due to federal guidelines. In those cases, your physician will give you a paper prescription to take to your pharmacy.

Refill requests will also be managed in the same manner. Please contact your pharmacy directly to request refills on your medications. They will send an electronic notification to your physician's nurse to obtain approval to refill the medication.

In order to effectively send your prescriptions to the correct pharmacy, we need to collect the following information:

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

or Cross Streets: _____

Pharmacy Phone Number: _____

Thank you and please let us know if you have any questions.

COMPREHENSIVE
CANCER CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Comprehensive Cancer Centers of Nevada 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 Comprehensive Cancer Centers of Nevada.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative *(if appropriate)*: _____

Signature of Personal Representative *(if appropriate)*: _____

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received:) _____ -OR-

Reason acknowledgment was not obtained: _____

_____

_____

_____

COMPREHENSIVE
CANCER CENTERS

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____	_____	_____
Patient Signature	SS #	Date

COMPREHENSIVE
CANCER CENTERS

Meaningful Use Update

Name: _____

Date of Birth: _____

Race/Ethnicity: _____

Preferred Language: _____

Preferred Method of Contact

Email: _____

Cell: _____

Home: _____

Other: _____

Marital Status

Married	Single	Widowed
Divorced	Life Partner	

COMPREHENSIVE
CANCER CENTERS

Nondiscrimination and Accessibility Requirements
Discrimination is Against the Law

Comprehensive Cancer Centers (Comprehensive) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Comprehensive Cancer Centers:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the practice manager/administrator.

If you believe that Comprehensive has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Lara Tobias, Business Office Director, Address: 400 N. Stephanie Street, Suite 300, Henderson, NV 89014, Tel: (702) 952-3350, Fax: (702) 952-3352, Email: infocccn@usoncology.com. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, the practice manager/administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

COMPREHENSIVE
CANCER CENTERS

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") 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 is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

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 quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

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

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

_____
Patient Name
(First Name, Middle Initial, Last Name)

_____
Date of Birth of Patient

☐ **I do not have e-mail access.**

☐ **I do not want access to the portal.**

Authorized user is:

_____
Authorized User Name (If different from patient)

- ☐ Patient
- ☐ Patient's Guardian (or parent of un-emancipated minor patient)
- ☐ Person authorized to make decisions on behalf of patient (*e.g.* by a medical power of attorney)

_____
Email Address of Patient or Authorized User

_____
Physician's Name

_____
Authorized Signature

_____
Date

_____
Signature of Practice Staff
[Confirming user's identity and authority]

_____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS_____	iKM Consent_____