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Summerlin

Radiation/CyberKnife

655 N. Town Center Drive
Las Vegas, Nevada 89144

Tel: 702.233.2200
Fax: 702.233.2210

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Summerlin Medical Center II

Medical Oncology/Breast Surgery

653 N. Town Center Drive, Suite 402
Las Vegas, Nevada 89144

Tel: 702.243.7200
Fax: 702.228.9410

COMPREHENSIVE CANCER CENTERS

Radiation Patient Questionnaire

Name: _____ Date of Consultation: _____

Problems that have led patient to seek medical attention here? _____

_____

_____

Please provide the names and phone numbers of your physicians (primary care, medical oncologist, surgeon, etc.)

_____

_____

Past Medical History

Chemotherapy: Have you ever had chemotherapy? If so, give date and place _____

_____

_____

Radiation Therapy: Have you ever had radiation therapy, radiation implants, cobalt treatment, etc.?

Yes No (if yes, please provide location, dates and phone numbers of center where you were treated) _____

_____

_____

Surgery: Please list all previous surgeries you've had and your approximate age at that time

_____

_____

_____

Accidents: Have you had any accidents or injuries of serious consequence? Yes No

Please list: _____

_____

Recent Hospitalizations: _____

Past Illness: Please check if you have history of, or currently have any of the following:

	Yes	No			Yes	No
Diabetes				Heart Trouble		
Kidney Disease				Phlebitis		
High Blood Pressure				Hepatitis B or C		
Bronchitis				HIV		
Seizures				Thyroid		
Tuberculosis				Back Pain		
Emphysema				Stomach Ulcers		
Liver Disease				Skin Disease		
Other						

Childhood Disease: _____

Current Medication (please list): _____

_____

Medication Allergies (please list): _____

_____

Family History:

	Alive	Current Age Age at Death	Cause of Death	List Any Cancer	Other Significant Medical Problems
Father	Yes No				
Mother	Yes No				

Any Family Members with cancer detected before age 50?_____
Please list any other family members who have had cancer:

Breast Cancer	Who _____	Other _____
Ovarian Cancer	Who _____	Other _____
Colon Cancer	Who _____	Other _____
Prostate Cancer	Who	Other

Social History:

Are you currently: employed retired unemployed on disability

Occupation: (current or former) _____

Marital Status: single married divorced widowed separated

Current living situation: (circle all that apply) alone with spouse significant other friend parent child other relative

Children: # males _____Ages _____# females _____Ages _____

Have you ever smoked? Yes No If yes, your age when you started _____Average packs per day _____

date quit (if applicable) _____.

Do you drink alcohol? Yes No What type _____How much per week _____

Did you ever drink large amounts of alcohol Yes No Date quit (if applicable) _____

Review of Systems:

Do you currently suffer form ay of the following:

General

Fevers	Yes	No		Hearing Loss	Yes	No
Night Sweats	Yes	No		Nose Bleeds	Yes	No
Poor Appetite	Yes	No		Dry Mouth	Yes	No
Weight Loss How many pounds?	Yes	No		Hoarse Voice	Yes	No
				Cataracts	Yes	No
				Glaucoma	Yes	No

Head and Neck

Cardiovascular System

Chest pain with effort	Yes	No		Heart Murmur	Yes	No
Palpitations	Yes	No		Ankle Swelling	Yes	No
				Pacemaker or implanted defibrillator	Yes	No

Pulmonary System

Cough	Yes	No		Shortness of Breath	Yes	No
Coughing Blood	Yes	No		Pain with Breathing	Yes	No

Review of Systems (continued):

Gastrointestinal System

Nausea	Yes	No		Yellow Skin (jaundice)	Yes	No
Vomiting	Yes	No		Clay Colored Stool	Yes	No
Constipation	Yes	No		Blood in the Stool	Yes	No
Diarrhea	Yes	No		Abdominal Pain	Yes	No
Have you ever had a colonoscopy?				If yes, when?		

Nervous System

Headaches	Yes	No		Tremors	Yes	No
Dizziness	Yes	No		History of Stroke	Yes	No
Paralysis	Yes	No		History of Seizure	Yes	No
Weakness of an arm or leg	Yes	No		Speech Disturbance	Yes	No
Loss of Sensation	Yes	No		Mental Illness	Yes	No

Musculoskeletal System

Arthritis	Yes	No		Limited Motions	Yes	No
Back Pain	Yes	No		Muscle Cramps	Yes	No

Hematologic

History of blood transfusions?	Yes	No		Treatment for anemia?	Yes	No
Any history of abnormal bleeding (i.e. with surgeries or dental work?)					Yes	No

Genitourinary System

Pain with Urination	Yes	No		Urgent Urination	Yes	No
Blood in the Urine	Yes	No		Incontinence	Yes	No
Frequent Urination	Yes	No		Retention of Urine	Yes	No

How many times per night do you wake up from sleep to urinate? _____

(For Men Only)

Do you have impotence? Yes No Partial Total

(For Women Only)

Date of last menstrual period _____. Date of last mammogram _____.

Age at menopause _____.

Number of pregnancies _____. Number of deliveries _____.

Age at first pregnancy _____. History of c-sections _____.

Hormonal Therapy Yes No Previous Current

Are you currently pregnant? Yes No Unsure

Could you possibly be pregnancy? Explain _____

COMPREHENSIVE
CANCER CENTERS

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name: _____ ( ) _____
Last First MI. Home Telephone

Home Address: _____ ( ) _____
Street Cell Telephone

_____ Date of Birth: _____
City State Zip

❑ M ❑ F Social Security # _____ ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other
Sex Check Marital Status

Patient's Employer(s): _____ ( ) _____
Name Telephone

_____ _____
Address Occupation

Insured's Employer: _____ _____ ( ) _____
Name Relationship Telephone

Contact:

Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship Telephone

Other Contact not living with you: _____ _____ _____
Name Relationship Phone#

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: ( ) _____

Policy Holder Name: _____ DOB _____ Group # _____ Policy# _____

Secondary Ins: _____ Telephone: ( ) _____

Policy Holder Name: _____ DOB _____ Group # _____ Policy# _____

_____ Initial
1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

_____ Initial
2. I authorize my insurance carrier to release information regarding my coverage to CCCN. I also authorize agents of any hospital, treatment center or previous physicians to furnish CCCN copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within CCCN

_____ Initial
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to CCCN. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to CCCN.

_____ Initial
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Comprehensive Cancer Centers of Nevada.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

_____ _____
Patient Signature Date/Time AM or PM

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM

EMPLOYEE INITIALS

CONFIDENTIAL

_____

Meaningful Use Update

Name: _____

Date of Birth: _____

Race/Ethnicity: _____

Preferred Language: _____

Gender:_____

Gender Identity:_____

Preferred Method of Contact

Email: _____

Cell: _____

Home: _____

Other: _____

Marital Status

Married	Single	Widowed
Divorced	Life Partner	

Employment Status

Full Time	Part Time
Retired	Unemployed

COMPREHENSIVE CANCER CENTERS

Date: _____

To: _____

_____

_____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AND OR RADIOLOGY STUDIES TO:

COMPREHENSIVE CANCER CENTERS OF NEVADA
655 N. TOWN CENTER DRIVE
LAS VEGAS, NEVADA 89144
702-233-2200 702-233-2210 FAX

PATIENT SIGNATURE _____

PRINTED NAME _____

ADDRESS _____

DATE OF BIRTH _____

IMPORTANT NOTICE:

DOCUMENTS/INFORMATION CONTAINED IN THIS FACSIMILE ARE CONFIDENTAL AND LEGALLY PRIVLIEGED AND ARE INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS FACSMILE IS NOT THE INTENDED RECIPENT, HE/SHE IS HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRUBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF THIS DOCUMENT HAS BEEN RECIVED IN ERROR, PLEASE IMMEDIATLEY NOTIFY THE SEND BY TELEPHONE. THANK YOU.

COMPREHENSIVE CANCER CENTERS

PATIENT CONFIDENTIALITY

Dear Patient:

As a service to the local health care community, Comprehensive Cancer Centers of Nevada cooperates with area teaching hospitals by providing an opportunity for medical and/or nursing students to gain clinical experience through observing patient care at our clinic. As a condition of their participation, each student is required to maintain the confidentiality of each patient's health care information and is prohibited from divulging any confidential health care information to any third party. The purpose of this form is to obtain your consent to the student' presence during your visits to our clinic and their access to your health care information.

CONSENT

Patient Name (Print): _____

Address:_____

_____

I hereby consent to the presence of medical and/or nursing students during my office visits at Comprehensive Cancer Centers of Nevada. By consenting to their presence during my examinations, I understand that I am allowing the students access to my health care information. I also understand that any students present during my office visits are obligated to maintain the confidentiality of my health care information and are prohibited from divulging any of my confidential health care information to any third party. U understand that I have the right to revoke this authorization at any time, but I must do so in writing. I Certify that I have read this form or have had it read to me, that I understand its contents, and that I have signed this form voluntarily.

_____ _____

Patients Signature Date

_____ _____

Or Authorized Representative (Name) Relationship to Patient

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 <u>received</u> 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):* _____

<u>Comprehensive Cancer Centers of Nevada Use Only</u>

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

Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC

PO Box 29901, Dept 948
Phoenix, AZ 85038-0901

Las Vegas CyberKnife at Summerlin

655 N Town Center Drive
Las Vegas, NV 89144

Welcome to our facility and our practice. We are committed to providing excellent care and to making this experience as comfortable as possible for you and your family. Dr. Curtis, Dr. Meoz, Dr. Sinopoli, Dr. Anderson, Dr. Cohen, Dr. Farzin and Dr. Schwartz are all board certified radiation oncologists providing services under the practice names Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC and Comprehensive Cancer Centers of Nevada.

With the additional demands you are experiencing, it is important for you to understand the process of scheduling your treatments, as well as our billing system. Appointments are scheduled here at the Las Vegas CyberKnife at Summerlin office. To make an appointment, please call 702-233-2200.

You will receive two bills for your treatment: one from Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC for technical charges, and one from Comprehensive Cancer Centers of Nevada for the physicians professional charges.

All of the billing for radiation oncology technical services provided at Las Vegas CyberKnife at Summerlin will be handled by AMAC on behalf of Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC. AMAC will prepare and submit your insurance claims for you and represent you as your advocate with insurance companies or other third party payers. AMAC will administer your account via a team approach to ensure a comprehensive and efficient handling of your insurance related matters. As a part of this team, your account manager is primarily responsible for assisting you but is supported by additional managers as well as a team leader. We encourage you to communicate with your representatives at AMAC. They are interested in assisting you with any questions or concerns regarding your insurance coverage and account balance. For questions regarding your statements from Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC, please call 800-228-3565, extension 6026. A patient representative will be happy to explain the billing to you and answer any questions you may have.

Contracting and provider enrollment is in progress with insurance carriers for the technical charges for services at Las Vegas CyberKnife at Summerlin. Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC may currently be out of network with your insurance company. If we are not yet participating providers with your insurance carrier then we are in the process of negotiating in network rates on your behalf with the insurance company for this treatment If you have any questions about the participating status of the practice, please call 800-228-3565, extension 6026.

As our patient, you are responsible for your bill. Please make sure all insurance information on file with our office is correct. Please also contact our billing office at 800-228-3565, extension 6026 and notify them of any changes to your insurance, pame, address, etc. If you receive a check paid directly to you from your insurance company, please endorse the check "Pay to the order of Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC" and then mail the check with a copy of the insurance company's explanation of benefits to:

Cohen, Curtis, Farzin, Meoz, and Schwartz, PLLC
PO Box 29901, Dept 948
Phoenix, AZ 85038-0901

Cohen, Curtis, Farzin, Meoz and Schwartz, PLLC
PO Box 29901, Dept 948
Phoenix, AZ. 85038-0901

Insurance and Billing Policy for Technical Fees Billed at Las Vegas CyberKnife at Summerlin

Our policy is to bill our technical fees to the patient after insurance has had the opportunity to consider the charges. Patient who are self-pay are responsible for the entire balance for all services rendered by the physicians at Las Vegas CyberKnife at Summerlin. Please advise our office if there are any changes in your insurance information. This will prevent you from being responsible for the full balance. Should you have any questions concerning your account, or if you wish to speak with your Account Representative, please call 800-228-3565, Ext 6026 between the hours of 6:00 a.m. and 2:00 p.m. Pacific time Monday through Friday.

I authorize Cohen, Curtis, Farzin, Meoz and Schwartz, PLLC, as well as other physician(s) related to my treatment, to bill my insurance company for charges incurred during the course of my treatment, and to provide any medical information necessary to process this claim. I understand that there may be additional charges for the surgeon that participated in the treatment planning process, and there may be a bill sent to me separately by them. I authorize payment to be made directly to Cohen, Curtis, Farzin, Meoz and Schwartz, PLLC and other physicia s related to my course of therapy, and a copy of this authorization may be used instead of the original. I authorize Cohen, Curtis, Farzin, Meoz and Schwartz, PLLC and other physician(s) related to my treatment to inquire about my accounts and to receive any information about any and all of my Medicare, Blue Shield, or other insurance claims assigned or non-assigned, and I understand that I am fully responsible for charges incurred with the treatment, even though the doctor files my insurance for me. I understand that delinquent accounts are subject to collection and acknowledge responsibility. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Cohen, Curtis, Farzin, Meoz and Schwartz, PLLC.

I have read and understand the above insurance and billing policy.

_____ _____

Patient and/or responsible party Date

_____ _____

Witness Date

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_____

COMPREHENSIVE
CANCER CENTERS

Patient Health Questionnaire (PHQ-9)

PATIENT NAME: _____ DOB: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (*circle your answer to indicate*)	**Not at All**	**Several Days**	**More than half the days**	**Nearly every day**
1) Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2) Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3) Trouble falling or staying sleep or sleeping too much	**0**	**1**	**2**	**3**
4) Feeling tired or having little energy	**0**	**1**	**2**	**3**
5) Poor appetite or overeating	**0**	**1**	**2**	**3**
6) Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7) Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8) Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9) Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
Add the Columns	**=**			

TOTAL: _____

10) If you have circled any problems, how difficult have these problems made if for you to do your work, take care of things at home or get along with other people?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

**Healthcare Professionals: For the interpretations of TOTAL please refer to your Scoring Card

COMPREHENSIVE CANCER CENTERS

Advanced Care Planning

At Comprehensive Cancer Centers of Nevada, we acknowledge that every patient has the right to have his or her personal values and goals of their care known and respected. Therefore, we are dedicated to work with every patient to plan our care to their values and goals. At any time should a patient's values and goals change, we will support these decisions throughout your care. Please share with us how valuable each of the following concerns is with you.

How valuable is it to me	Not Valuable	Unsure	Valuable
My independence and ability to remain active	○	○	○
Nutrition	○	○	○
Sleep	○	○	○
Spirituality and/or religion	○	○	○
Adequate pain management	○	○	○
Relationship with my family/loved ones/friends	○	○	○
Clear communication with my medical team regarding treatment plans/prognosis	○	○	○

How valuable is it to me to…	Not Valuable	Unsure	Valuable
Choose who will make my medical decisions for me, should I become unable to do so?	○	○	○
Choose where my medical care will take place when I am nearing the end of my life, i.e., home, hospice, etc.?	○	○	○
Have nutritional intake, even if it requires an IV or feeding tube, due to my not being able to chew or swallow food?	○	○	○
Be able to take deep breaths, even if it requires assistance from a breathing machine or any other life sustaining mechanics?	○	○	○

1) I HAVE already completed the following advance care planning documents. *Please check all that apply and provide a copy of each.*

   ☐ **LIVING WILL** ☐ **POWER OF ATTORNEY for HEALTH CARE** ☐ **POLST or DNR**

2) I would like an office visit with an advance practice practitioner (NP/PA) to discuss Advanced Care Planning.

   ☐ **YES** ☐ **NO**

PATIENT NAME: _____ DOB: _____ DATE: _____