Today's Date: _____ Patient Name: _____

COMPREHENSIVE
CANCER CENTERS

Souzan El-Eid, MD, FACS
Patient Questionnaire

Patient Name: _____ Age: _____
Referring Physician (name/address/phone number): _____
Primary Care Physician (name/address/phone number): _____
OB/GYN(name/address/phone number): _____
Reason for visit: _____

Medical History

Please check if you have a history of any of the following:

	YES	NO		YES	NO
Breast Cancer			Kidney Stones (s)		
Ovarian Cancer			Epilepsy		
Uterine Cancer			Arthritis		
Cervical Cancer			Nervous Disorder		
BRCA 1			Depression		
BRCA 2			Stroke		
Ulcer			Heart Disease		
Colitis			High Blood Pressure		
Crohn's Disease			Osteoporosis		
Ulcerated Colitis			Osteopenia		
Diverticulitis			Thyroid Disease		
Colon Cancer			Lung Disease		
Cancer			Back Disorder		
Asthma/Emphysema			Blood Disease or Anemia		
Blood Clotting Disorder			Autoimmune Disease		
High Cholesterol			HIV		
Hepatitis (jaundice/liver disease)			Diabetes		

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

Have you ever had radiation therapy? If so, give date and place _____

SURGERY HISTORY (please include all breast biopsies as well)

Surgery	Date	Surgery	Date
1) _____		4) _____	
2) _____		5) _____	
3) _____		6) _____	

SCREENING EXAMS

Date of last mammogram: _____
Date of last bone density/osteoporosis scan _____
Date of last colonoscopy _____
Other imaging studies: _____
Where do you have your scan/imaging studies done? _____

Patient Name: _____

Please check if you CURRENTLY have any of the following symptoms

	YES	NO		YES	NO
Fatigue			Nausea/Vomiting		
Weight Change			Constipation		
Vision Changes			Diarrhea		
Hot Flashes			Burning with Urination		
Sinusitis			Blood in Urine		
Ringing in the ears			Irregular Periods		
Sore Throat			Painful Periods		
Chest Pain			Muscle Pain		
Palpitations			Back Pain		
Ankle Swelling			Skin Rash		
Cough			Depression		
Shortness of Breath/Wheezing			Anxiety		
Heartburn			Other		
Abdominal Pain					

Allergies

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Current Medications and Supplements (include over the counter medications)
Please list name of medication, dose and frequency

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

	Mother	Father	Brother	Sister	Son	Daughter	Other (please note if maternal/paternal grandmother, grandfather, aunt, uncle)
	(please mark alive or deceased)						
Breast Cancer	_____	_____	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____	_____	_____
Endometrial Cancer	_____	_____	_____	_____	_____	_____	_____
Cervical Cancer	_____	_____	_____	_____	_____	_____	_____
Uterine Cancer	_____	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____	_____
Pancreas Cancer	_____	_____	_____	_____	_____	_____	_____
Melanoma	_____	_____	_____	_____	_____	_____	_____
BRCA-1	_____	_____	_____	_____	_____	_____	_____
BRCA-2	_____	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____

Patient Name: _____

Stroke	_____	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY

Ethnic Background: White Hispanic African American Asian Middle Eastern Other _____

Father's Background: _____

Mother's Background: _____

Primary Language: _____

Are you currently: Employed Retired Unemployed Disabled

Occupation: _____

Marital Status: Single Married Divorced Widowed Separated

Do you drink alcohol? _____ What type? _____ How much per week? _____

Did you ever drink large amounts of alcohol? _____ Date quit (if applicable):_____ Any use of recreational drugs? _____ Type? _____ Have you ever smoked? Yes No If yes, what was your age when you started? _____ Average packs per day: _____

Date quit (if applicable): _____

OB/GYN HISTORY

Pap Smear Yes _____ No_____ Date _____

Age of first period _____ Date of last menstrual period _____

Age of Menopause _____

Periods Regular _____ Irregular _____

Are you currently pregnant? _____

Pregnancies: ___ # Live births ____ Age at first pregnancy: ____ Age at first delivery: _____

Vaginal, how many? _____ C-Section, how many? _____

Full Term _____

Currently breast feeding? Yes No

Did you breast feed? Yes No

How long did you breast feed (each birth) _____

Any history of hormone replacement? Yes No

Any history of birth control? Yes No

Do you drink caffeine products? Yes No

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

Patient Financial Policy

We, the staff at Comprehensive Cancer Centers of Nevada, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to speak to a Patient Benefits Representative who is available in the office where your care is provided. Insurance Specialists are also available to answer questions Monday through Thursday from 8:30 AM to 5 PM at our Central Business Office at (702) 952-3350. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, co-pay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by insurance programs. We may also present charges to you by written statement or letter via the mail following a visit. If we do this, we expect that each charge will be paid in full the first time it is presented to you.

We make payment as convenient as possible. Payment may be made in person at any of our locations or by return mail, by phone call or via our payment portal at www.cccnevada.com. We accept cash, money order, MasterCard, Visa, American Express, Discover and in-state checks. A $25 service fee will be charged for all returned checks.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

We will remind you of unpaid charges monthly by statement through the mail. If, after four statements, charges remain unpaid and you have not made payment arrangements, you may be contacted in writing or by phone by a third party. By accepting our services, you are consenting to receive these communications.

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payment, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Missed Appointments
We currently do not charge for missed appointments. We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Timeliness of Appointments
We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy.

Patient Name (Please Print): _____

Signature of Insured or Authorized Representative: _____

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

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

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

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

Date: _____

Patient Name: _____

I hereby authorize:

Souzan El-Eid, MD, FACS
Comprehensive Cancer Centers
653 N. Town Center Drive, Suite 402 Las Vegas, NV 89144
Tel: 702.255.1133
Fax: 702.255.0582

To release any and all of my medical records to:

_____

_____

_____

_____

Print Name: _____

Signature: _____ Date: _____

Date of Birth: _____

PLEASE RELEASE THE FOLLOWING:

☐ History & Physical	☐ Mammograms	☐ Diagnostic Tests
☐ Pathology	☐ All Recent Labs	
☐ ER, PR & DNA Studies	☐ Last Progress Notes	

Other: _____

_____

_____

_____

COMPREHENSIVE
CANCER CENTERS

Date: _____

Patient Name: _____

I hereby authorize:

_____

_____

_____

_____

To release any and all of my medical records to:

Souzan El-Eid, MD, FACS
Comprehensive Cancer Centers
653 N. Town Center Drive, Suite 402
Las Vegas, NV 89144
Tel: 702.255.1133
Fax: 702.255.0582

Print Name: _____

Signature: _____ Date: _____

Date of Birth: _____

PLEASE RELEASE THE FOLLOWING:

☐ History & Physical	☐ Mammograms	☐ Diagnostic Tests
☐ Pathology	☐ All Recent Labs	
☐ ER, PR & DNA Studies	☐ Last Progress Notes	

Other: _____

_____

_____

_____