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: ___________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Relationship</th>
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<tbody>
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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
Patient Questionnaire

Name: __________________________   Date: ________________

Date of Birth: __________________ Age: _________

Primary Care Physician: _____________________ Referring Physician: __________________

Other physicians: ______________________________________________________________
____________________________________________________________________________

What is the main problem you are here for?
____________________________________________________________________________

Have you had any of the following diseases, and about how old were you when you had it or it started?

<table>
<thead>
<tr>
<th>Diseases/Illness</th>
<th>Age</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ Diabetes</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Kidney Disease</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Liver Disease</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Rheumatic Fever</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Seizures</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Asthma/Emphysema/COPD</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Heart Disease</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Blood Clots</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Thyroid Problems</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Nerve or Brain Problems</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Depression or Anxiety</td>
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<td>____________________________</td>
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<tr>
<td>__ Blood Problems</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Rheumatoid Arthritis</td>
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<td>____________________________</td>
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<tr>
<td>__ High Blood Pressure</td>
<td>___</td>
<td>____________________________</td>
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<tr>
<td>__ Others</td>
<td>___</td>
<td>____________________________</td>
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</tbody>
</table>

Previous Surgeries

____________________________________________________________________________

Date
____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Vaccines (please list date)

Tetanus ________  Pneumovax ________  Flu ________  Zostavax ________

Cancer Screening (please list date)

Colonoscopy ______________

Mammogram ________________

PSA Check ________________  Level? ________________

Pap smear _________________

Please list all of your medications, herbal supplements, vitamins or complimentary/alternative treatments:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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</table>

Are you allergic to any medications?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reaction</th>
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</table>

Pharmacy you would like prescriptions called into: ____________________________

Phone#: ___________________

Social History

Do you smoke:    _____yes    _____no

Did you smoke in the past?  _____yes    _____no
Age start _____ Age stop ______

Cigarettes ____ Pack/day ______

Cigars _____ #/day ______

Pipe _____ Pipes/day ______

Do you drink alcohol?   ____yes   ____no

How much? What type? ______________________

Did you ever drink alcohol?   ____yes   ____no   Date quit? __________

Are you currently: employed retired unemployed on disability

Occupation: ____________________________________________

Marital Status: single married divorced widowed separated

Children: # of sons _____ ages ________________ any illness ______________________

# of daughters _____ ages ________________ any illness ______________________

Family History

<table>
<thead>
<tr>
<th>Alive?/Age</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>____________________________</td>
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<tr>
<td>Mother</td>
<td>____________________________</td>
</tr>
<tr>
<td>Brothers</td>
<td>____________________________</td>
</tr>
<tr>
<td>Sisters</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

Review of Systems

**Constitutional:**  ____fever  ____sweats  ____weight loss  ____how much?

____pain(rate 1-10)____  ____fatigue(rate1-10)____

**Head:**  ____headache  ____dizziness

**Ears:**  ____deafness  ____ringing in ears

**Eyes:**  ____pain  ____decrease vision  ____double vision  ____spots before eyes

**Nose:**  ____bloody nose  ____nasal obstruction

**Throat:**  ____sore  ____blood in mouth  ____sore spots  ____hoarseness
Chest: ____cough ____cough with blood ____shortness of breath ____pain with breathing
Heart: ____chest pain ____palpitations ____ankle swelling ____difficulty lying down
Abdomen: ____pain ____nausea ____vomiting ____hepatitis ____jaundice ____constipation ____diarrhea ____blood in stool ____black tarry stool
Urinary: ____pain ____bleeding ____incontinence ____difficulty in starting flow
Reproduction: Last menstrual period_________ how many days? ____ heavy Y/N
breast self exam ____yes ____no
number of pregnancies ____ number of live birth____
are you pregnant ____yes ____no
age at onset of periods ____
have you ever used hormones? ____yes ____no
have you ever taken birth control? ____yes ____no
Neurological: ____numbness ____weakness ____trouble walking ____poor coordination
Skin: ____rash ____itching ____moles ____lumps
Hematology: ____abnormal clotting ____abnormal bleeding ____blood disorders
Blood Transfusion  Y/N  Date: ______ How much? _______ units

For office use:
Temp _____ HR _____ RR_____ B/P _____ Height _____(in) Weight _____(lbs)
BSA _____(m2)

Date: ________ RN/MA ____________________
Cancer Family History Questionnaire

Please complete this form to the best of your ability and bring it to your next scheduled visit with your physician. This information will assist your physician in knowing the cancers that may run in your biological (blood related) family. When you complete the table below, please include your information as well as information for your parents, sisters, brothers, sons, daughters, grandparents, aunts, uncles, and first cousins. Please sign the form.

Date Form Completed: _____________________ Date of Birth: ____/____/_____
Print Name: ___________________________ Patient’s Signature: ___________________________

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Who was/is affected?</th>
<th>At what age was the cancer type found?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovarian</td>
<td></td>
<td>For Example: Dad, 45 years old</td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td>Mom, 67 years old</td>
</tr>
<tr>
<td>Uterus</td>
<td></td>
<td>Son, 56 years old</td>
</tr>
<tr>
<td>Colon/rectal</td>
<td></td>
<td></td>
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<tr>
<td>Prostate</td>
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</tbody>
</table>

Are there any other cancers that run in your family?
_____________________________________________________

Are you of Ashkenazi Jewish descent?  □ YES  □ NO
Are you of African American descent?  □ YES  □ NO

Have you or anyone in your blood related family had 20 or more lifetime colon polyps?  □ YES  □ NO

Has anyone in your family had cancer genetic testing? ______ If yes, explain: ____________________________

Are you concerned about your personal and/or family history of cancer? _____________________________

For Healthcare Provider/Staff completion:

Recommendations:  □ Refer for Genetic Counseling (by MD order or physician standing order).
                  □ No Genetic Counseling referral indicated at this time.
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:

☐ 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  Date
[Confirming user’s identity and authority]

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 of Nevada uses electronic prescriptions to manage 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.