21st Century Oncology

Dr. Vicki Philben, MD and Dr. Maja Sandberg, MD

963 Butte Street Redding, California 96001

530-244-3921

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE WILL PLEASE NEED THE FOLLOWING INFORMATION. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Name_____

Today's date_____ Date of birth_____ Age_____

Referring physician_____ Primary care provider_____

Why did you come to the office today? _____

Was your breast problem detected by yourself_____physician_____ mammogram_____?

How long have you known about it? _____

Has anything changed since you first noticed it? _____

Any other breast symptoms, such as nipple discharge or skin changes? _____

Any previous breast surgery or breast biopsies? _____

Right_____Left_____ Date_____Place_____

Findings_____

Age at menarche (first menstrual period) _____

Date last menstrual period_____

Age at first live birth_____ Number of pregnancies_____ Number of children_____

Did you breast feed? _____ If so, how long? _____

Is there any chance you could be pregnant now? _____

Age at menopause_____ natural_____ surgical _____

Have you ever taken estrogen? _____ If so how long? _____

If you took estrogen previously, when did you stop? _____

Are you taking estrogen now? _____

Do you have a family history of breast cancer? _____ If so, please indicate:

Relationship	Age at diagnosis	Current state of health

Any family history of ovarian cancer? _____

Are you of Ashkenazi Jewish descent?_____

Has anyone in your family undergone genetic testing? _____

Family History:

RELATIONSHIP	MEDICAL PROBLEMS	AGE	CAUSE OF DEATH IF DECEASED
Mother			
Father			
Sister(s)			
Maternal grandmother			
Paternal grandmother			
Maternal grandfather			
Paternal grandfather			
Any other relatives with cancer of any type?			

Have you or anyone in your family had:

Blood clots? _____ Problem with bleeding? _____

Problems with anesthesia? _____ Sickle cell anemia/trait? _____

YOUR PAST MEDICAL HISTORY:

Any active medical problems?

_____

_____

Have you ever had any operations? _____ If so, please list the operations, date performed and where they were done? _____

_____

Any other hospitalizations (not including the operations listed above)? If yes, please list the reason, date, and hospital_____

_____

Have you ever had radiation treatments? _____

Allergies and type of reaction_____

Are you allergic to latex? _____

Are you taking any drugs, medications, laxative, birth control pills, hormones, pain pills, vitamins, or herbal products? If so, please list:

MEDICATION	WHY TAKING?	DOSAGE	HOW OFTEN?

DRUGS:

Have you taken steroids in the past year? _____

Do you use any recreational or illicit drugs? _____

Have you ever been an IV drug user? _____

TOBACCO:

Have you ever smoked? _____ If you do not smoke now, when did you quit? _____

How much do you (did you) smoke per day? _____ For how many years? _____

ALCOHOL:

Do you drink alcohol? _____ If yes, how much? _____

How often? _____ Have you ever had a problem with alcohol? _____

SOCIAL HISTORY:

Marital status_____

Occupation (if retired, what was your usual occupation) _____

Who lives in your household? _____

PLEASE NOTE IF YOU HAVE HAD ANY OF THE FOLLOWING:

General:	**Recent weight loss_____**
	Recent weight gain_____
	High Blood Pressure_____
	Night sweats_____
	Fatigue_____
	HIV/AIDS_____
Throat/Mouth:	**Dentures_____**
	Missing/loose teeth_____
	Tooth abscess_____
	Oral cancer_____
Eyes:	**Cataracts_____**
	Glaucoma_____
	Double vision_____
Musculoskeletal:	**Blood clots in legs (phlebitis)_____**
	Arthritis_____
	Pain in joints_____
	Difficulty walking_____
	Broken bones_____
	Major injury_____

PLEASE NOTE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Musculoskeletal:	**Weakness in arms/legs_____**
	Osteoporosis_____
Neurological:	**Strokes_____**
	TIA's_____
	Epilepsey_____
	Memory loss/Alzheimer's_____
	Numbness/tingling_____
Psychiatric:	**History of depression_____**
	History of psychiatric problems_____
Hematologic:	**Problems with platelets_____**
	Anemia_____
	Bleeding problems_____
	Problems with blood clots_____
Gyn:	**History of abnormal PAP_____**
	Uterine cancer_____
	Ovarian cancer_____
	Endometriosis_____
	Abnormal vaginal bleeding_____
Skin:	**Chronic skin problems_____**
Endocrine:	**Diabetes_____**
	Thyroid disease_____
	Adrenal disease_____
	Parathyroid disease (high calcium)_____
Ears:	**Hearing aids_____**
	Chronic ear infections_____
	Deafness_____

PLEASE NOTE IF YOU HAVE HAD ANY OF THE FOLLOWING:

GU:	**Any changes in bowel movements_____**
	Blood or blackness in your bowel movements_____
	Pancreatitis_____
	Ulcers_____
	Hernias_____
	Colon cancer_____
	Gallbladder disease_____
	Bowel obstruction_____
	Reflux (heartburn)_____
	Liver problems_____
	Hepatitis_____
Kidney Problems:	**Any blood, pain or burning w/urination_____**
	Incontinence_____
	Cancer of bladder or kidneys_____
Cardiovascular:	**Chest pain (angina) _____**
	Heart attack_____
	Heart murmur_____
	Heart failure_____
	Heart surgery_____
	Palpitations, rapid irregular heartbeats_____
	Coronary arteriogram (cardiac catheterization) _____
Pulmonary:	**Asthma_____**
	Wheezing_____
	Chronic cough_____
	Chronic bronchitis_____
	Shortness of breath_____

PLEASE NOTE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Pulmonary: **Sleeping with extra pillow to breathe easier_____**

Tuberculosis (TB)_____

Lung cancer_____

Blood clot in lungs (pulmonary embolus)_____

IF ANY ITEMS WERE CHECKED, PLESE EXPLAIN:

_____
_____
_____
_____
_____
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_____
_____

ANYTHING ELSE WE SHOULD KNOW?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT SIGNATURE_____

Redding Cancer Treatment Center
963 Butte Street, Redding CA 96001 ● (530) 244-3921
Fax Number (530) 244-5639

Thank you for choosing our office.
In order to serve you properly we will need the following information. (PLEASE PRINT)
All information will be held confidentially

Patient's Name	Home Phone Number	Birthdate / /	Marital Status
Residence Address	City	State	Zip Code
Mailing Address: (If Different)			Cell Phone Number
Name of Employer		Social Security Number	
Work Phone Number	Occupation	Business Address	
Do you have Health Insurance? ☐ Yes ☐ No	If no, how do you intend to pay? ☐ Check ☐ Cash ☐ Credit Card Care Credit ☐ Need to see financial coordinator * Visa/Mastercard are Accepted		
Medi-Cal Pending? ☐ Yes ☐ No	Person Financially responsible for this account: ☐ Self ☐ Other_____		
Primary Insurance Name	Policy No.	Is this through your employer? ☐ Yes ☐ No	
Name of Primary Insured	Birthdate / /	Spouse's Social Security Number (if different from insured)	
Name and Address of Spouse's Employer		Spouse's Business Phone Number	
Secondary Insurance ☐ Yes ☐ No	Insurance Company Name and Address		
Policy Number	Name of other Physicians who care for you?		
Next of Kin: Relationship: Address and Phone Number:			
If for any reason you are unable to make medical decisions whom would make them for you? Name and Address:	Relationship:	Phone Number:	
Do you have a telephone answering machine in your home? ☐ Yes ☐ No May we call you at work? ___Yes___No If so, may we leave messages from this office on that machine? ☐ Yes ☐ No			
Emergency contact NAME_____RELATIONSHIP_____ PHONE_____			
Patient's or Guardian Signature	Date		

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Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number

Address (Street, City, State, ZIP Code)	Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical Information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**
_____	
_____	
_____	

*__DO NOT__ discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**
_____	
_____	
_____	

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date:

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

Redding Radiation Oncologists, PC
PO BOX 79682 CITY INDUSTRY, CA 91716-9682

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

Notice of Privacy Practices
Redding Radiation Oncologists, PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:
- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:
- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

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Redding Radiation Oncologists, PC

Other Uses of Your Protected Health Information That Require Your Authorization
Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

Changes to This Notice
We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

Redding Radiation Oncologists, PC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

****

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ❑ Patient/family member received notice but refused to sign acknowledgment
- ❑ Emergency treatment situation
- ❑ Patient was incapacitated and no family member was present
- ❑ Unable to communicate due to language barriers
- ❑ Other (please describe below)

_____
_____

_____ _____
Signature of Employee Date