

Welcome

Thank you for choosing Phoenix Cyberknife and Radiation Oncology.

In an effort to make your initial visit both pleasant and efficient, we have several patient information forms to be completed before your appointment. This information will be used to prepare your medical chart.

Please complete these forms and bring them with you 30 minutes prior to your appointment, or you may fax or mail the completed forms to our office prior to your appointment. When you arrive, we will photocopy your insurance card and driver's license. If you have a copy of your medical records and or radiology scans on CD, you are welcome to mail, fax or bring them by our office, as our providers like to review your history 1 to 2 days prior to your appointment. Also note that some of the paperwork will be for Honor Health, these forms are for billing purposes for your treatment.

If your insurance company requires a referral or authorization number for you to see a specialist, please contact your primary care physician for the necessary referral or authorization number. Any co-payments for the initial consultation are payable at the time of service. We accept cash, check or credit cards.

A nurse will be seeing you prior to your visit with the physician. At that time she will go over your medications and medical history, so please bring your medications and a list of any physicians currently involved in your care.

If you have any questions or need assistance, please feel free to call our office between 7:30am and 4:30pm, Monday through Friday.

On behalf of Phoenix Cyberknife and Radiation Oncology, we look forward to meeting you and helping you with your medical needs.

Sincerely,

Your Phoenix Cyberknife and Radiation Oncology Team

Phone 602-441-3845

Fax 602-464-9769

**AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By signing below I give permission for the institution listed to disclose my protected health information to Phoenix Cyberknife and Radiation Oncology Center:

Person/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This protected health information is being used or disclosed for the following purpose:  
Medical consultation, follow-up appointment, and/or treatment

Information to be disclosed \_\_\_\_\_ Dates (if known): \_\_\_\_\_

- Most Recent History and physical
- Discharge summary
- Initial consultation note
- Most Recent progress note
- All radiology reports and imaging discs or dates specified: \_\_\_\_\_
- All Operative reports or dates specified: \_\_\_\_\_
- All Pathology reports or dates Specified: \_\_\_\_\_
- Most recent laboratory results
- Chemotherapy records
- Radiation therapy records: Initial Consult, treatment summaries, treatment plans, plan images.
- Other \_\_\_\_\_

Date by which the information is needed: \_\_\_\_\_

Send Records to:  
4611 E SHEA BLVD, SUITE 120  
PHOENIX, AZ 85028  
P: 602-441-3845  
F: 602-464-9769

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

You may revoke this authorization in writing at any time by sending written notification to Phoenix Cyberknife and Radiation Oncology Center, 4611 E. Shea Blvd, Ste 120, Phoenix, AZ 85028. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

This agreement will expire one year from the date of signature unless cancelled by the patient/guardian.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian / Patient Representative / Relationship to patient

\_\_\_\_\_  
Date

**PATIENT PERSONAL INFORMATION**

Name : \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
Race:  White  Black or African American  American Indian or Alaska Native  Native Hawaiian or Pacific  
Islander  Other \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Non-Latino  Unwilling to Provide  Unknown  
Address: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Domestic Partnership  
Social Security #: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**  Same as Above

Responsible Party \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Patient  Self  Spouse  Other \_\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_  
Street Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**PATIENT INSURANCE INFORMATION Please present insurance card at check-in**

Name of Insured \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_  
Patient relationship to Insured  Self  Spouse  Other \_\_\_\_\_  
Insurance ID \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_  
Patient relationship to Insured  Self  Spouse  Other \_\_\_\_\_  
Insurance ID \_\_\_\_\_ Group # \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
*Street, City, State, Zip*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Are we able to discuss your medical information with your emergency contact:  Yes  No

**Medical Power Of Attorney** (If applies, provide copy)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Executor of your Estate** (If applies, provide copy)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Living will**                      Yes or No                      If yes, please provide copy

**I have received a copy of the Privacy Rules from this practice**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**How were you referred you to our office?**

*Please check one:*

- Previous patient of our office: \_\_\_\_\_  Facebook/LinkedIn  Insurance Provider  
 Friend/Family  TV/Commercial  Phoenix Magazine  PCROC Website  Google Search  
 Physician (Name): \_\_\_\_\_  Other \_\_\_\_\_

Name : \_\_\_\_\_ DOB: \_\_\_\_\_

To help us ensure continuity of care, please provide us with the following list of all doctors involved in your care. If at any time, you add, change or drop a physician please let our office know so that we may continue to keep the proper doctors informed. Thank You.

OTHERS NOT LISTED

Specialty: \_\_\_\_\_ Name: \_\_\_\_\_

Phone#: \_\_\_\_\_ Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Name: \_\_\_\_\_

Phone#: \_\_\_\_\_ Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Name: \_\_\_\_\_

Phone#: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Location: Major Cross Road \_\_\_\_\_

Name :

DOB:

Age:

Brief Explanation for Today's Visit:

Past Medical History:

Have you had radiation treatment in the past?  Yes  No

If yes, to what part of body? \_\_\_\_\_

When: \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility: \_\_\_\_\_

Have you had chemotherapy in the past?  Yes  No

When: \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility: \_\_\_\_\_

Are you currently undergoing chemotherapy?  Yes  No

Date of last dose: \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility: \_\_\_\_\_

Any previous surgeries:  Yes  No

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Implanted Devices: Do you have any implanted or metal devices?  Yes  No

Venous Access Device/Type \_\_\_\_\_  Pacemaker  Aneurysm Clip

Screws, pins, plates/Where? \_\_\_\_\_  Stent  Other \_\_\_\_\_

Do you have?  Diabetes  Thyroid Problems  Other:

Smoking History:

Have you ever smoked?  Yes  No (If yes, please answer the following questions)

Do you currently smoke?  Yes  No # of Packs per Day: \_\_\_\_\_ Number of years: \_\_\_\_\_

If you have quit smoking: When: \_\_\_\_/\_\_\_\_/\_\_\_\_

Alcohol Consumption:

Do you consume alcohol?  Yes  No

If yes: How often? \_\_\_\_\_ How much? \_\_\_\_\_

Controlled Substance Usage:

Do you currently use controlled substances?  Yes  No

If yes: What substance? \_\_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_

Gynecological: (Females Only)

# of Children: \_\_\_\_\_ # of Pregnancies: \_\_\_\_\_ # of live births: \_\_\_\_\_ Other: \_\_\_\_\_

How old were you when your 1st child was born? \_\_\_\_\_

Did you breastfeed?  Yes  No How Long? \_\_\_\_\_

Age at 1st Menstrual Period: \_\_\_\_\_ Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Pelvic Exam/PAP: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hormones:  Yes  No Name: \_\_\_\_\_ How Long? \_\_\_\_\_  
 Hysterectomy:  Yes  No When: \_\_\_\_/\_\_\_\_/\_\_\_\_ Why? \_\_\_\_\_  
 Do you do self breast exams?  Yes  No How often? \_\_\_\_\_  
 Type of birth control currently used: \_\_\_\_\_  
 Date of last mammogram: \_\_\_\_/\_\_\_\_/\_\_\_\_ Facility: \_\_\_\_\_

**Family History:**

Is there any family history of cancer?  Yes  No (If yes; Who? And what type of cancer?)

**Allergies:**

None  
 Latex Reaction: \_\_\_\_\_  
 Medications: Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_  
 Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_  
 Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in

**Please provide us with a list of current medications:**

| Medication | Dosage | Frequency | Purpose of Medication |
|------------|--------|-----------|-----------------------|
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\*\*\*If you need more space, please use reverse side\*\*\*

**Review of Systems:** (please check all that apply to your health)

**General:**

Please rate your level of fatigue 0-10 (0=none, 10=severe): \_\_\_\_\_  
 Are you now experiencing pain?  Yes  No If so, where? \_\_\_\_\_  
 Please rate your pain level 0-10 (0=none, 10=severe): \_\_\_\_\_  
 Do you experience any of the following?  
 Fever  Chills  Night Sweats  Sleep Problems  
 Please explain: \_\_\_\_\_

**Skin:**

- No problems  
 Rashes  Itching  Skin Cancers  Burn easily in sun  Other \_\_\_\_\_

**Heart:**

- No Problems  
 Blood Pressure Problems  Bruising/Bleeding  Palpitations  
 Swollen Ankles  Heart Attack/when? \_\_\_/\_\_\_/\_\_\_  Other \_\_\_\_\_

**Neurological:**

- No Problems  
 Memory Loss/Forgetfulness  Fainting Spells/Dizziness  Visual Complaints  Claustrophobia  
 Seizures/Convulsions  Headaches/Migraine History  Hearing Complaints  Stroke  
 Other \_\_\_\_\_

**Respiratory:**

- No Problems  Received Flu Vaccine: Month/Year: \_\_\_\_\_  
 Shortness of Breath:  At Rest  With Activity  
 Home Oxygen (LPM\_\_\_\_)  Hoarseness  Breathing Medications  Asthma  Other: \_\_\_\_\_  
Do you have a cough?  Yes  No If yes, does it produce:  Blood or  Phlegm?

**Skeletal/Muscular:**

- No Problems  
 Arthritis  Numbness/Tingling  Weakness/Balance Problems  Back/Neck Pain  
 Blood Clots: Where? \_\_\_\_\_  
 Collagen Vascular Disease (i.e. Lupus, Scleroderma, etc.)

**Digestive:**

- Appetite:  Good  Fair  Poor  
Weight Loss: Have you lost weight in the last 6 months?  Yes  No If yes, How much?: \_\_\_\_\_  
 No Problems  
 Nausea/Vomiting  Heartburn/Reflux  Ulcers/Hiatal Hernia  Swallowing Problems  
 Sores in Mouth  Chewing Problems  Dentures  
 Other \_\_\_\_\_  
Do you follow a special diet? (If so, please explain) \_\_\_\_\_

Date of last Colonoscopy: \_\_\_\_\_

**Urinary**

- No Problems  
 Burning  Frequent  Discomfort  Catheter  Ostomy  Urinary Tract Infections  
 Incontinence (unable to hold bladder)  Other \_\_\_\_\_

**Bowel**

- No Problems  
 Diarrhea  Constipation  Stool Incontinence (loss of control)  Ostomy  
 Liver Disease/Hepatitis  Other \_\_\_\_\_  
Last BM: \_\_\_\_\_ Frequency of BM: \_\_\_\_\_



If you have further information, which you feel would allow us to provide you with better care, or have special needs that must be addressed, please write it in the space below.

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Patients Name:

Date of Birth:

**Please Initial next to each section:**

\_\_\_\_\_ I hereby agree to pay for services rendered when charges are incurred, unless previous arrangements have been made. In the event of default, I agree to pay any collections costs and/or attorney fees as may be required to effect collection of charges incurred.

\_\_\_\_\_ I understand I will be receiving a bill from both RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER separately and authorize both entities to bill my insurance company for charges related to my treatment.

\_\_\_\_\_ I hereby authorize RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER to release any information acquired in the course of my examination or treatment. I also authorize photocopies of this form and my signature to be valid as the original.

\_\_\_\_\_ I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER.

\_\_\_\_\_ I hereby authorize payment directly to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance. I also guarantee that all the information I have provided is current and correct, and I understand that I am responsible for financial loss due to inaccurate/outdated information I provide.

\_\_\_\_\_ I will notify RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER. Immediately with any insurance, address or contact information changes. Otherwise I will be held responsible for all actions incurred by inaccurate/outdated information.

\_\_\_\_\_ If eligibility of insurance cannot be verified, or if deductible, out of pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered and payable to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and/or PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER.

\_\_\_\_\_ I request that payment of authorized Medicare, Medicare HMO and all other plans benefits be made either to me or on my behalf to RADIATION ONCOLOGISTS OF CENTRAL ARIZONA and/or PHOENIX CYBERKNIFE AND RADIATION ONCOLOGY CENTER for any services furnished to me by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

\_\_\_\_\_ I understand if I arrive after my appointment time there may be a significant wait as the clinic tries to work me into the schedule. I understand I may not be able to be seen and will be rescheduled as those who arrived on time will have priority over me.

I hereby authorize photocopies of this authorization and my signature to be as valid as the original.

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF SPOUSE/GUARANTOR: \_\_\_\_\_ DATE \_\_\_\_\_

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Phoenix Cyberknife and Radiation Oncology LLC is dedicated to protect your "nonpublic personal health information." This is to tell you how and why we collect that information, and who has access to that information.

**HOW WE COLLECT YOUR INFORMATION:**

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card and driver's license. This ensures you that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain the information from the hospital. However, on your first visit to this office we will ask you to fill out our information sheet to insure that the information we received from the hospital was correct.

We may also ask a doctor or other healthcare provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

**WHY WE COLLECT THIS INFORMATION:**

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

**MAINTAINING ACCURATE AND TIMELY INFORMATION:**

To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

**WHO HAS ACCESS TO THIS INFORMATION?**

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and this practice has no jurisdiction over such entities.

**HOW WE PROTECT YOUR INFORMATION:**

We release your records only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

If you leave this practice, your Protected Health Information will continue to receive the protection outlined in this notice.

**COMPLAINTS/COMMENTS:** If you have any complaints concerning our privacy practices, you may contact the privacy officer of this practice at 602-441-3845.

This Practice reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to our policy will be posted in our office. This notice is effective as of February 21, 2013.