CANCER CENTER ONCOLOGY MEDICAL GROUP
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Other

Social Security #:	Birth Place: City,State,Country	Birth date: / /	Age:	Sex: ❑ M ❑ F

Ethnicity/Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/ African American ❑ Pacific Islander/Native Hawaiian ❑ Hispanic/Latino ❑ White ❑ Other ❑ Patient Declined

Street address:	Home phone no.: ( )	Cell phone no: ( )

P.O. box:	City:	State:	ZIP Code:

Spouse/Parent Name:	Spouse/Parent Phone Number: ( )

Occupation:	Employer:	Employer phone no.: ( )

May we contact you at work: _____Yes _____No Email:

How did you hear about our clinic (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Community Event ❑ Website ❑ Internet ❑ Other

Other family members seen here:

May we give any medical information/results: **to your spouse:** ❑ Yes ❑ No **on your answering machine:** ❑ Yes ❑ No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CANCER CENTER ONCOLOGY MEDICAL GROUP or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

NAME:_____ DATE OF BIRTH:_____ AGE:_____ DATE_____

SURGERIES (include skin, eye, orthopedic, etc.):

Type of surgery	Month/Year	Type of surgery	Month/Year
1.		4.	
2.		5.	
3.		6.	

MEDICAL HISTORY (i.e. ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.):
Please list the medical problem that prompted you to see the doctor.

Type of problem	Approx. Date of Onset	Type of problem	Approx. Date of Onset
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Last Menstrual Period_____ Number of Pregnancies_____

FAMILY HISTORY (Cancer, diabetes, dementia, coronary disease, osteoporosis, other):

	DECEASED OR LIVING	AGE (CURRENT OR AT DEATH)	DIAGNOSIS OR CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING			
SIBLING			

OF SONS_____ ILLNESSES_____

OF DAUGHTERS_____ ILLNESSES_____

HABITS:

DID YOU OR DO YOU USE TOBACCO? YES_____NO_____ IF YES, AMOUNT?_____

DID YOU OR DO YOU USE ALCOHOL? YES_____NO_____IF YES, AMOUNT?_____

HAVE YOU EVER BEEN TREATED FOR DRUG ADDICTION? YES_____ NO_____ IF YES, WHEN?_____

HOW MANY CUPS OF COFFEE OR OTHER CAFFEINATED BEVERAGES DO YOU DRINK PER DAY?_____

CALCIUM INTAKE: SUPPLEMENTS/DAIRY PRODUCTS (AMOUNT, TYPE FREQUENCY)_____

EXERCISE: TYPE_____ DURATION_____FREQUENCY_____

CANCER CENTER ONCOLOGY MEDCIAL GROUP
5555 GROSSMONT CENTER DRIVE
LA MESA, CA 91942
619-644-3030 FAX 619-644-3638

REVIEW OF SYMPTOMS

GENERAL
- ☐ WEIGHT LOSS
- ☐ FATIGUE
- ☐ LOSS OF APPETITE
- ☐ NIGHT SWEATS
- ☐ FEVER
- ☐ CHILLS

EYES
- ☐ BLURRED VISION
- ☐ DOUBLE VISON
- ☐ DIFFICULTY SEEING

EARS,NOSE,THROAT
- ☐ HEARING LOSS
- ☐ RINGING IN EARS
- ☐ SINUS TROUBLE
- ☐ DIFFICULTY SWALLOWING
- ☐ SORE THROAT
- ☐ NASAL DRAINAGE
- ☐ NOSE BLEEDS
- ☐ HOARSENESS

CARDIAC
- ☐ CHEST PAINS
- ☐ HEART PALPATATIONS
- ☐ LIGHT HEADEDNESS
- ☐ SWELLING OF LEGS
- ☐ EPISODES OF PASSING OUT

RESPIRATORY
- ☐ COUGH
- ☐ SPUTUM PRODUCTION
- ☐ COUGHING UP BLOOD
- ☐ SHORTNESS OF BREATH
- ☐ SLEEP APNEA

GASTROINTESTINAL
- ☐ NAUSEA
- ☐ VOMITING
- ☐ HEARTBURN
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ ABDOMINAL PAIN
- ☐ RECTAL BLEEDING
- ☐ BOWEL INCONTIENENCE

GENITO-URINARY
- ☐ VAGINAL BLEEDING
- ☐ BURNING ON URINATION
- ☐ PAIN WITH URINATION
- ☐ BLOOD IN URINE
- ☐ FREQUENT URINATION
- ☐ URINARY INCONTINENCE

MUSCULO-SKELETAL
- ☐ MUSCLE PAIN
- ☐ STIFFNESS
- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ BACK PAIN

SKIN
- ☐ RASH
- ☐ OTHER SKIN COMPLAINTS

NEUROLOGICAL
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ DIZZINESS
- ☐ LOSS OF BALANCE
- ☐ WEAKNESS IN LIMBS
- ☐ LOSS OF SENSATION
- ☐ TINGLING SENSATION
- ☐ MEMORY LOSS
- ☐ DIFFICULTY THINKING

PSYCHIATRIC
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ RESTLESSNESS
- ☐ DIFFICULTY SLEEPING

HEMATOLOGIC/LYMPATIC/IMMUNOLOGIC
- ☐ BRUISING
- ☐ BLEEDING
- ☐ LUMPS IN ARMPITS
- ☐ LUMPS IN NECK
- ☐ LUMPS IN GROIN

PLEASE INDICATE IF YOU HAVE ANY ADDITIONAL PROBLEMS:

_____

_____

_____

Cancer Center Oncology Medical Group
5555 Grossmont Center Drive
La Mesa, CA 91942
Tel (619) 644-3030 Fax (619) 644-3638

Medication form

NAME:_____ **DATE:**_____

DOB:_____ **PREFERRED PHARMACY:**_____

ALLERGIES: (For example: medications, food, and/or other substances)

[illegible]	Allergic Reaction (What symptoms occur?)

VACCINES: Please check one for each vaccine.

Tetanus	Pneumonia	Influenza
☐ within past 10 years	☐ within past 5 years	☐ within the past year
☐ unknown	☐ unknown	☐ unknown

MEDICATION I TAKE:
Information the doctor will want to know for each medication:

Why are you taking it?
How long have you been taking it?
What is the dosage?
How many times a day do you take the medication? (If you are not sure, bring the medication with you.)

[illegible]	Dose	Number of Times Taken Per Day	Date Started	[illegible]

OTHER MEDICATION I TAKE:
Remember to include on your list any over the counter (OTC) medicine you take (vitamins, herbs, pain relievers, supplements, etc.).

***Please note if you are unable to complete this form, please bring your medications with you in the original bottles.**

Cancer Center Oncology Medical Group
5555 Grossmont Center Drive
La Mesa, CA 91942
Tel (619)644-3030 Fax (619) 644-3638

CONSENT TO PROCEDURES

The undersigned consents to the services provided by Cancer Center Oncology Medical Group. The undersigned acknowledges that these services have been adequately explained, and all questions have been answered.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be provided to the patient, he/she is obligated to pay the charges. We bill patients' insurance as a courtesy, however, it is the patients' ultimate responsibility for payment for services provided.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment of the insurance benefits to which I may be entitled directly to Cancer Center Oncology Medical Group. Requested information may be released to the Insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care Insurances generally require that a representative, often a Primary Care Physician, authorize services and diagnostic procedures before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payment if you receive services that are not authorized as required by your plan.

NOTICE TO MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process claims. I also request payment of government benefits to the party who accepts assignment.

Patient Name (Print)_____

Patient Signature _____ Date: _____

Or

Designated agent's signature: _____ Date: _____

Relationship to patient: _____

A photocopy of this form may be deemed as valid

Cancer Center Oncology Medical Group
5555 Grossmont Center Drive
La Mesa, CA 91942
Tel: (619)644-3030 Fax: (619)644-3638

STATEMENT OF FINANCIAL POLICY

Dear Patient:

Thank you for choosing Cancer Center Oncology Medical Group as your provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). If you have questions, please let us know. Our billing office can be reached at (619) 644-3030 ext. 124 from 8:30am to 5:00pm.

1. **Insurance:** Your insurance policy is an agreement between you and your insurance company, we are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
    a. Non-contracted insurances: if we are not contracted with your insurance company, Please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs, but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services:** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurances. If this is the case we will inform you and require you to sign an ABN form. You will be responsible for any charges.
3. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance:** All patients must complete a patient information form before seeing the physician. We will ask for a copy of your current insurance card(s) as proof of insurance and valid identification.
5. **Coverage change:** If your insurance changes, please notify our office immediately. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments: All co-payments must be paid at the time of service.**
7. **Non-Payment:** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Payment:** For your convenience, we accept cash, checks and credit cards. We accept Visa, MasterCard and Discover.
9. **Financial Counselor:** We have a Financial Counselor available as a resource to our patients. Please call (619)644-3030 ext. 127 if you need assistance.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Print Name Relationship to Patient

NO SHOW/MISSED APPOINTMENT POLICY

We, at Cancer Center Oncology Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 619-644-3030

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Cancer Center Oncology Medical Group and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Cancer Center Oncology Medical Group will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office.

6. If you have 3 "No-Show/Missed" appointments within a one-year time, dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Cancer Center Oncology Medical Groups No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Cancer Center Oncology Medical Group appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date

Patient Signature or Parent/Guardian if minor	Relationship to Patient

CANCER CENTER ONCOLOGY MEDCIAL GROUP
5555 GROSSMONT CENTER DRIVE, LA MESA, CA 91942
Phone: 619-644-3030 Fax: 619-644-3638

DAVID BODKIN, M.D.
KAI ZU, M.D.
REEMA BATRA, M.D.
IGOR MEDIC, M.D.
KRISTIN ELO, P.A.-C
STEFANIE SACKNOFF, P.A.-C
AMY WRAY, P.A.-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

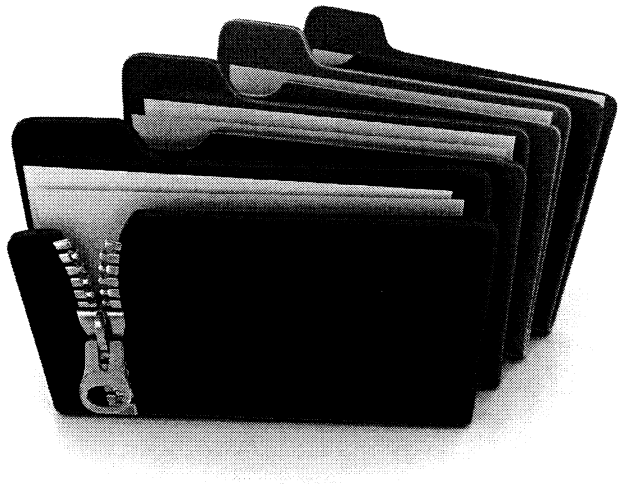
_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____.

Signature _____

Date _____

DHCS
California Department of
HealthCareServices

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413
(866) 866-0602 or (877) 735-2929 TTY/TTD
http://dhcs.ca.gov/privacyoffice



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Conduct outreach, enrollment, care coordination and case management	• We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.
Appeal a DHCS decision	• We can share your information if you or your provider appeal a DHCS decision about your health care.
Apply for full scope Medi-Cal	• If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Join a managed care plan	• If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.

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Administer our programs	• We can share your information with our contractors and agents who help us administer our programs.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

We will never market or sell your personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

- This notice applies to all DHCS programs, including Medi-Cal. For a full list of programs currently run by DHCS, please visit our website at **www.dhcs.ca.gov/services.**

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or Braille.

DHCS does not have full copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor, dentist, or health plan first.

DHCS
California Department of HealthCareServices

DHCS Privacy Officer

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413

Phone: **(866) 866-0602** Option 1, or (877) 735-2929 TTY/TTD
Fax: (916) 440-7680
Email: privacyofficer@dhcs.ca.gov