CANCER CENTER ONCOLOGY MEDICAL GROUP

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Dear New Patient:

Welcome. Please find enclosed paperwork that will be needed for your first visit to our facility.

To reduce your waiting time in our office, please take a few minutes to complete the enclosed forms before your arrival.

Also, please be sure to bring the following information with you to our office when you arrive for your appointment:

1. Completed initial paperwork.

2. All pertinent insurance cards, including your prescription card and current identification.

3. All medications that you are currently taking, including over-the-counter medications and vitamins and supplements.

4. Please arrive 30 minutes before your scheduled appointment time.

If you have any question please feel free to contact our office at 619-644-3030 ext. 132. Thank you for taking the time to complete this very important paperwork. Our entire staff looks forward to meeting you.

Sincerely,

Cancer Center Oncology Medical Group

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:

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:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ 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)

Allergy	Allergic Reaction (What symptoms develop?)

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.)

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

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

Other Medication	Dose	Number of Times Taken Per Day	Date Started

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

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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

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

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KAI ZU, M.D.
REEMA BATRA, M.D.
IGOR MEDIC, M.D.
KRISTIN ELO, P.A.-C
ERIN VAWTER, 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.

Cancer Center Oncology Medical Group

The Sunshine Act and Open Payments

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

This data is published annually in a database known as Open Payments. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I hereby acknowledge that I have been offered a copy of Cancer Center Oncology Medical Group's notice of Open Payments. I have been advised that a copy of the notice is posted in the reception area and a copy of this acknowledgement will be placed in my chart.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

PATIENT NAME (please print) PATIENT DATE OF BIRTH

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

_____	_____
Date	Patient's Name (Type or Print)
	_____
	Patient's Signature
_____	_____
Date	Patient Representative's Name and Relationship (Type or Print)
	_____
	Patient's Representative's Signature

Original to be maintained in patient's medical records.

CANCER CENTER ONCOLOGY MEDICAL GROUP

5555 GROSSMONT CENTER DRIVE
LA MESA, CA 91942
PHONE 619-644-3030
FAX 619-644-3638

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 an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is 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 say "yes" to all reasonable requests.

continued on next page

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.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

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 your care • Share information in a disaster relief situation • Include your information in a hospital directory • 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 • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• 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.

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, in our office, and on our web site.

06/22/2017

This Notice of Privacy Practices applies to the following organizations.

DEBBIE MASON, OFFICE MANAGER/SECURITY OFFICER 619-644-3030 619-644-3638

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 _____