PHOENIX CANCER Institute

Patient Registration Form

Patient Name:_____ Birth Date:_____ Gender: M__ F__

Permanent Address: _____City:_____ State: _____

Zip Code:_____ Home Phone: _____ Cell Phone:_____

Office may Leave a detailed message: Yes No

Email: _____ Marital Status: Single Married Divorced Widow/widower

Social Security Number: _____ Employment Status: Full time Part-Time Unemployed Retired Disabled

Race: _____ Ethnicity: _____ Preferred Language: _____

Referring Doctor:_____ Referring Doctor Phone Number: _____

Insurance Information

Primary Insurance: _____

Policy# / SSN# : _____

Insurance Address: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relationship to patient: _____

Secondary Insurance: _____

Policy# / SSN# : _____

Insurance Address: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relationship to patient: _____

Authorization, Assignment And Release

I Authorize Phoenix Cancer Institute to perform evaluation and treatment, as they deem necessary. I further authorize my insurance company to pay Phoenix cancer Institute all medical benefits. I understand that ultimate i am responsible for all charges not covered by my insurance company. I, Also, understand I will be responsible for all collection and legal fees, if my account is placed with an outside collection agency.

I hereby Authorize this office to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic

_____ _____

Signature of Insured **Date**

PHOENIX CANCER Institute

967 Hancock Rd Ste 133
Bullhead City, AZ 86442
o. 928.224.0064 • f. 480.842.8608 •
phoenixcancer.com

Authorization of release of information

Patient Name: _____ **Date of birth:** _____

☐ I Authorize Phoenix Cancer Institute to obtain information from my medical records from:
☐ I Authorize Phoenix Cancer Institute to release information from my medical records to:

Facility:

Name:_____ Phone Number:_(_____) ____- _____

Address: _____ City: _____ State/Zip code: _____

Emergency Contact:
Name: _____ Phone Number:_____

Relationship to patient: _____

Family Member/friends:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Please provide the following information from my medical records:
☐ duplicate copy of ALL medical records

I hereby consent to the release of all medical records pertaining to treatment/diagnosis except as follows: _____

_____

_____

The purpose of this request is for:

☐ Further medical care
☐ Insurance
☐ Radiology (all films are the property of the clinic & must be returned within 30 days)
☐ Other

I understand that this authorization shall expire, without my express revocation, 1 year from the date written below. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Patient signature: _____ **Date:** _____
Or
Patient representative
signature: _____ **Date:** _____

Witness/office
Employee signature: _____ **Date:** _____

PHOENIX CANCER Institute

Medication History Retrieval

This form will be used to retrieve medication list and information from your pharmacy. However, in order to obtain this information we need your approval. Please check yes that you would like us to obtain medication information.

_____ Yes please obtain my medication history.

_____ No you may not obtain my medication history.

_____ _____

Patient Signature **Date**

_____

Print Patient Name

In addition, we can send your prescription needs to your pharmacy electronically. However, to be able to do this we require the name and location of your pharmacy.

_____

Pharmacy Name

_____

_____

Address, City, State and Zip code

_____

Pharmacy Telephone number

PHOENIX CANCER Institute

ACKNOWLEDGEMENT OF RECEIPT OF NOTIFICATION OF PRIVACY PRACTICES

Phoenix Cancer Institute is committed to protecting your privacy and ensuring that your health information is disclosed appropriately. This Notice of Privacy practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy practices.

I acknowledge I have received a copay of the Notice of Privacy Practices of Phoenix Cancer Institute.

Patient or personal Representative (please print): _____+

Patient or personal Representative (Signature): _____

Date: _____

****

For Office Use Only"

Reason acknowledgement was not obtained: _____

_____

_____

Employee Initials: _____ Doctor: _____ MRN #: _____

Health History

PHOENIX CANCER Institute

Patient Name: _____ Date of Birth: _____Date:_____

How did you learn about our clinic? _____

Medical History: Do you have any of the following medical conditions?

___High Blood pressure	___History of stroke	___History of colon polyp(s)
___High cholesterol	___History of blood clot	___History of lung nodule(s)
___Diabetes	___History of heart attack	___Cataracts
___Acid reflux (GERD)	___Gout	___Visual impairment
___Osteoporosis	___COPD, emphysema	___Hearing loss
___Heart Disease	___Asthma	___Fibromyalgia
___Atrial fibrillation	___Anemia	
___Overactive thyroid	___Abnormal platelets	Other chronic medical conditions:
___Underactive thyroid	___Abnormal WBC count	_____
___Autoimmune disease	___Depression	_____
___Chronic kidney disease	___Anxiety	_____

Are you on blood thinners? ____ No ____ Yes

Do you have a pain contract? ____ No ____ Yes If yes, name of pain doctor: _____

Have you ever been seen by a blood or cancer doctor? ____ No ____ Yes

If yes, please list details: _____

Have you ever had cancer? ____ No ____ Yes If yes, please answer the following:

- Type of cancer: _____
- Chemotherapy: ____ No ____ Yes
- Radiation: ____ No ____ Yes
- Surgery for cancer: ____ No ____ Yes
- Where did you have treatment? _____
- Name of treating physicians: _____

Have you ever been diagnosed with a blood disorder? ____ No ____ Yes

If yes, please list details: _____

Have you ever had a bone marrow biopsy? ____ No ____ Yes

Other providers involved in your care:

Name of primary care provider: _____

Other providers:_____

Surgical History:

Have you ever had a surgical procedure? ____ No ____ Yes If yes, please list here:

Date:	Type:	Facility:

Implanted Devices: Please mark if you have any of the following devices:

Picc Line / Port _____

Pacemaker _____

Aneurysm Clip _____

Screws, pins, plates. If yes, Where? _____

Have you ever been told you cannot get an MRI? ____ No ____ Yes

Do you have any allergies? ____No ____Yes If yes please list allergies and reactions below:

_____

_____

Current Medications:

Medication	Strength	Frequency	Prescriber	Purpose of medication

Cancer Screening:

All patients:

Have you ever had a colonoscopy? ____ No ____ Yes Cologuard? ____ No ____ Yes

If yes, year of last study: _____ History of abnormal result? _____

Have you ever had lung cancer screening? ____ No ____ Yes

If yes, year of last study: _____ History of abnormal result? _____

Have you ever had a DEXA (bone density scan)? _____ No ____ Yes If yes, year: _____

Women only: _____

Have you ever had a mammogram? ____ No ____ Yes

If yes, year of last mammogram: _____

History of abnormal mammograms or breast cancer? _____

Have you ever had a pap smear:? ____ No ____ Yes

If yes, year of last pap: _____

History of abnormal paps? _____

Men only:

Have you ever had a PSA test? ____ No ____ Yes (If yes, year of last test: _____)

History of abnormal PSA or prostate cancer? _____

Obstetrics/Gynecology history (WOMEN only)

Are you pregnant? _____ No _____ Yes

Is there a chance you could be pregnant? _____ No _____ Yes

Age of 1st menstrual period: _____

Date of last menstrual period: _____

Age of Menopause (if applicable): _____

Hysterectomy: _____ No _____ Yes If yes, were ovaries removed? _____ No _____ Yes

Type of birth control currently used: _____ ____N/A

Do you use oral contraceptives: _____ No _____ Yes ____N/A

Do/did you use hormone replacement: ____ No ___ Yes If yes, For how long? _____

Number of pregnancies: _____ Number of live births: _____ Age at first full term pregnancy: _____

Other health questions:

Do you wear dentures: _____ No _____ Yes

Do you have dental work that is needed or planned: _____ No _____ Yes

Please indicate if you use any of the following regularly:

____ crutches _____ wheelchair _____ walker _____ cane _____ other

Do you have a Durable Power of Attorney for healthcare? ____ No ___ Yes

If yes, please list their name: _____

If no, are you interested in getting information about DPOA paperwork? _____ No _____ Yes

Family History: _____ Mark here if family history unknown

Father : _____ Alive ___ Deceased ___ age Cause of death: _____

Mother: _____ Alive ___ Deceased ___ age Cause of death: _____

SIblings: Number of Sisters _____ Brothers _____

Have any of your family members been diagnosed with a blood disorder or cancer? ___ No ___Yes

Family member	Type of cancer/blood disease	Age at time of diagnosis	Alive/ Deceased	If deceased, cause of death

Social History:

Are you Married: _____ No _____ Yes

What is your occupation: _____ _____Retired

Do you live: ___ Alone ___ with spouse/significant other ___ with family ___ assisted living
___homeless ____other

Any children: _____ No _____ Yes If yes, how many? _____

Do you have a religious and or cultural belief we should be aware of during treatment?
_____ No _____ Yes

If yes, please describe:_____

Substance History:

Do you or have you ever smoked? _____ No _____ Yes If yes, please answer the following:

Do you currently smoke cigarettes: _____ No _____ Yes

How much or did you smoke: Packs per Day: _____ How many years: _____

Do you use chewing tobacco? _____ No _____ Yes

If you no longer smoke, date you quit: _____

If you still smoke, are you interested in trying to quit? _____ No _____ Yes

If you have tried to quit, what have you tried: __patches __gum __chantix __wellbutrin

Do you or have you ever consumed alcohol? _____ No _____ Yes

If yes, How many drinks per week do you currently consume? _____

If you no longer consume alcohol, when did you stop? _____

Do you use recreational drugs? _____ No _____ Yes

If yes, which drugs? ____marijuana ____cocaine ____heroin ____meth ____other

Review of Systems (please check all symptoms you have experienced in the past 12 months) :

_Weakness
_ Fatigue
_ Fever
_ Shaking/chills
_ Night Sweats
_Appetite change
_Weight loss
_Weight gain

_Rash
_Skin lumps
_Skin sores
_Itching
_Skin dryness
_Skin color change

_Vision changes
_Hearing loss
_Ringing in ears
_Vertigo
_Earaches
_Nasal congestion
_Nasal discharge
_Nosebleeds
_Sinus trouble
_Dry mouth
_Hoarseness

_Neck lumps
_Neck pain
_Neck stiffness
_Goiter

_Breast lumps
_Breast pain
_Nipple discharge
_Nipple retraction
_Lumps in armpit(s)

_Chest pain
_Palpitations
_Shortness of breath
_Waking up short of breath
_Unable to sleep lying flat
_Leg swelling

_Cough
_Sputum
_Coughing up blood
_Wheezing

_Trouble swallowing
_Heartburn
_Nausea
_Vomiting
_Diarrhea
_Rectal bleeding
_Dark tarry stool
_Constipation
_Abdominal pain
_Incontinence of stool

_Frequent urination
_Frequent urination at night
_Urinary urgency
_Burning with urination
_Blood in urine
_Frequent UTIs
_Incontinence of urine

_Pain in legs with walking
_Leg cramps

_Muscle pain
_Joint pain
_Back pain
_Muscle tenderness
_Decreased range of motion

_Headaches
_Dizziness
_Lightheadedness
_Fainting/black-outs
_Seizures
_Paralysis
_Numbness/tingling
_Tremors
_Involuntary movements
_Balance issues

_Heat or cold intolerance
_Excessive sweating

_Nervousness
_Depression
_Memory change
_Difficulty thinking

Patient Signature: _____ Date: _____

PHOENIX CANCER Institute

Patient Management Expectations

Hello and welcome to Phoenix Cancer Institute! We are so happy to have you as our patient. Below are some guidelines and explanations about how the clinic works. Please initial each statement.

_____Phone calls: If we are unable to answer your call and you leave a message on voicemail, we will return the call as soon as possible, but please allow up to 2-3 business days to return your call due to high patient call volume. If you are calling about an emergency, call 911. Multiple phone calls about the same issue are not required.

_____Medication refills: Please allow 3-5 business days for all medication refills. To avoid delays, please notify us at least 5-7 business days in advance of the date that refills will be due.

_____Care team: At PCI we manage our patients as a team. This means that follow-up appointments may be with the primary oncologist or may be with other physicians or advanced practice practitioners on the care team.

_____Controlled substance management: For patients with cancer-related pain or anxiety, we often prescribe controlled substances to help with these symptoms. The goal is to taper off these medications after the cancer is treated. Some patients will require a taper plan agreement at the clinician's discretion. For patients unable to taper off the controlled substances following successful cancer treatment, they will be referred back to their PCP or pain doctor for ongoing management.

_____Paperwork: Most paperwork will require an appointment so it can be completed accurately based on each patient's specific needs. Please allow 5-10 business days for completion of the paperwork from the date of the appointment, although most paperwork will be completed on the day of the appointment.

_____Respectful behavior towards staff: We strive to foster a supportive and positive environment. All employees are working very diligently on each patient's behalf, often-times behind the scenes. Disrespectful behavior by the patient or family members (or their friends) will not be tolerated under any circumstance, including but not limited to yelling, cursing, physical aggression, verbal abuse over the telephone, etc. This kind of behavior may result in dismissal from the clinic.

_____We strive to keep your bills as low as possible, which is why we have made the PCI promise of seeking grant support, providing the lowest cost treatment regimens as long as efficacy is equivalent, and working to stay in network with insurance companies. We do not make treatment decisions based on what is most profitable for our clinic. Therefore, we expect that patients keep up to date with their bills and notify our clinic if additional assistance is needed or if insurance changes occur.

_____Missed appointments: Our clinic runs best for patients and staff when patients are on time and do not miss scheduled appointments. Please call at least 24 hours in advance if you need to reschedule your appointment to avoid a $35 fee. We understand emergencies come up, so please call our office to keep the lines of communication open.

_____At this time, visitors are not able to stay in the treatment room while patients are getting chemotherapy for patient safety, privacy and comfort of other patients, and limited space. Thank you for your understanding.

_____Clinician cell phone number: In some cases our clinicians have given out their cell phone numbers in order to follow up on specific issues. Following that specific situation, and outside of urgent issues, please direct all other general calls to the main clinic phone number.

_____We now fill all specialty medication prescriptions (e.g. oral chemotherapy) in our PCI Specialty Pharmacy, and will refer to an outside specialty pharmacy only if we are unable to fill the prescription. If we become able to fill the specialty prescription, the prescription will be transferred to our pharmacy at the time of the next refill.

_____For prescriptions being filled at other pharmacies, please notify us immediately if you are being charged what seems to be an unreasonable amount of money – we work to limit out of pocket expenses, but we need to be aware of them when they come up!

_____Telemedicine visits are utilized when appropriate since the beginning of the Covid-19 pandemic. As with in-person visits, you are responsible for any copay that is required by insurance.

_____Our team works diligently to move care forward as quickly as possible. However, there are delays that can occur outside of our control due to insurance, outside providers, hospitals, imaging centers, etc. Please make us aware when delays are occurring so we can provide timely guidance on the best way to proceed.

_____The majority of results are communicated during clinic appointments to allow for the appropriate time to discuss impacts on diagnosis, prognosis, and management. If you have a result that is ready, please call and request to move up your appointment time if needed.

_____Please notify our clinic when you are admitted to a hospital or have a notable change in health status. This allows our staff to request records and discuss your case with colleagues if indicated.

_____ We strive to keep the clinic schedule running on time; however, there are days when appointment delays will occur due to unexpected issues that arise with our patients. We appreciate your patience when this happens.

_____Family members and friends are an important part of the care team and are welcome and encouraged to attend clinic visits. Please note that all communication about a patient's care takes place during appointments. If family members are unable to be physically present, they can participate over the phone. We do not call family members outside of clinic appointments, so please plan appointment times accordingly.

_____Most phone calls to patients to assess symptoms and answer questions are addressed by our highly capable nurses and other staff members as deemed appropriate. Provider calls to patients outside of appointments occur primary when immediate treatment or care decisions need to be made. Less urgent matters are addressed during appointments.

_____All treatments are administered at our clinic (eg chemotherapy, EPO-stimulating agents, IV iron, etc) and cannot be arranged at other institutions (eg Lake Havasu, Kingman, Parker, etc; this does not apply to orders like blood transfusions that are only done at the hospitals).

_____All above statements must be acknowledged with initials to establish care.

Sincerely, Your Care Team at PCI

Patient Signature:_____ Date: _____