CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

TODAY'S DATE ____________________

PATIENT INFORMATION

Last Name ________________________ First Name ____________________ Middle ____________

Date of Birth ______________________ Social Security # _________________

Home Phone # ____________________ Cell Phone # ____________________

Place of Birth ____________________ Race _______________ Marital Status __________________

Mailing Address: ________________________ City _______________ State ______ Zip __________

Local address during treatment if different ___________________________ Local Phone # ___________

Email Address ____________________________________

EMPLOYER _______________________________ Address ______________________________

Occupation ___________________________________ Work Phone# __________________________

Name of Spouse _________________________ Date of Birth _________ Social Security # __________

Employer _______________________________ Work Phone # ____________ Cell # ____________

Close Friend or Relative ___________________ Relationship ____________ Phone # ____________

Referring Physician _________________________ **Primary Care Physician** ___________________

Other Current Physicians ____

INSURANCE INFORMATION

Primary Insurance Carrier ____________________ Name of Insured ___________________________

Medicare Number _________________________

Secondary Insurance Carrier __________________ Name of Insured ___________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Carson Tahoe Radiation Oncology Associates physician for the medical benefits for services rendered. I hereby authorize Carson Tahoe Radiation Oncology Associates to release any and all information necessary to process this claim.

SIGNED ___________________________________ DATE ________________________

Rev. 05/02/17

Acknowledgement of Receipt of Notice

RADIATION ONCOLOGY ASSOCIATES, CHARTERED

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES, CHARTERED

Privacy Officer: Gary E. Campbell, M.D., (775) 883-5505

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed*: ______________________________ Date: ____________________

Print Name: ___________________________ Telephone: ________________

*If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ________________________________

For office use only:

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of this medical practice's Notice of Privacy Practices.

Name of Patient: ____

Reason for refusal/failure: ____

____

____

___________________________________ ____________________

Employee's Signature *Date*

File Signed Copy with Patient's Record

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES
CURRENT REVIEW OF SYSTEMS

Name:________________________________ **Date:** ____________________

Please check each item "yes" or "no" as they relate to your health:

CONSTITUTIONAL:	Yes	No
Weight loss	___	___
Fatigue	___	___
Fever	___	___
EYES:		
Glasses/contacts	___	___
Double vision	___	___
Cataracts	___	___
EARS, NOSE, THROAT:		
Difficulty hearing	___	___
Ringing in ears	___	___
Vertigo	___	___
CARDIOVASCULAR:		
Chest pain	___	___
Dizziness	___	___
Shortness of breath	___	___
Difficulty lying flat	___	___
Swelling of ankles	___	___

RESPIRATORY:	Yes	No
Cough	___	___
Coughing blood	___	___
Wheezing	___	___
GASTROINTESTINAL:		
Heartburn/reflux	___	___
Nausea/vomiting	___	___
Constipation	___	___
Change in BMs	___	___
Diarrhea	___	___
Abdominal pain	___	___
Black or bloody BM	___	___
GENITOURINARY:		
Burning/frequency	___	___
Blood in urine	___	___
Erectile dysfunction	___	___
Bladder leakage	___	___

MUSCULOSKELETAL:	Yes	No
Joint pain/swelling	___	___
SKIN:		
Rash/sores	___	___
Itching/burning	___	___
NEUROLOGICAL:		
Loss of strength	___	___
Numbness	___	___
Headaches	___	___
PSYCHIATRIC:		
Anxiety/depression	___	___

Date of last colonoscopy:___________

Patient MEDICAL History

Diabetes	___Yes ___No
Hypertension	___Yes ___No
Cancer	___Yes ___No
Stroke	___Yes ___No
Heart Trouble	___Yes ___No
Arthritis/Gout	___Yes ___No
Depression	___Yes ___No

Patient FAMILY History

Mother	Father
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No
___Yes ___No	___Yes ___No

Allergies: ____

Patient SOCIAL History

Marital Status: ____Married ____Single ____Separated ____Divorced ____Widowed
Use of Alcohol:____ Yes ____No Use of Tobacco:____Yes ____No
Use of Drugs: ____Never ____Type/Frequency____________________

Medications and Supplements:

1. ____________________ 4. ____________________

2. ____________________ 5. ____________________

3. ____________________ 6. ____________________

Patient's Signature____________________________

Rev. 05/02/17

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

Gary E. Campbell, M.D. Beth L. Hummer, M.D.
Diplomates, American Board of Radiology
Sandra L. Shirley, PA-C

PATIENT AUTHORIZATION FORM

PATIENT NAME: ____
(please print)

It is the policy of Carson Tahoe Radiation Oncology Associates (CTROA) to make confirmation phone calls to patients on the day before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly:

My appointment	yes	no
My medical care	yes	no
My patient account	yes	no

Also, if I am not available, I authorize the staff of CTROA to speak with the following individual(s) regarding my care. yes no

NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER

I authorize the staff of CTROA to call my work/cell number, if I am otherwise not available. yes no

I also authorize the staff of CTROA to leave a message on my voice mail at my work number. yes no

I understand that it is the policy of CTROA to take a photo of each patient for their patient chart.

______________________________ ______________________
Patient or guardian signature Date

Rev. 1/2015

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES
Gary E. Campbell, M.D.   Beth L. Hummer, M.D.
Diplomates, American Board of Radiology
Sandra L. Shirley, PA-C

I, ____, authorize the release of my medical records (including face sheet, insurance information, pathology, operative reports, history and physical, x-ray reports, labs, and doctors' follow-up notes) to Carson Tahoe Radiation Oncology Associates.

I also authorize the release of my medical records from Carson Tahoe Radiation Oncology Associates to doctors that I may be referred to.

PATIENT ____

Guardian's Signature ________________________________

Date ____

Date of Birth of Patient _____________________________

Revised 1/2015

1535 Medical Parkway, Suite A, Carson City, Nevada 89703
Telephone 775-883-5605   Fax 775-883-6779

CARSON TAHOE RADIATION ONCOLOGY ASSOCIATES

Diplomates, American Board of Radiology

Billing Address: P.O. Box 21300 Reno, Nevada 89515-1300

Dear Patient:

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to call our business office. The following is our Financial Policy.

We ask that all patients read and sign our Financial Policy as well as complete a Patient Information Form on your first visit.

Payment for services can be made in several different ways. We accept CASH, CHECKS or CREDIT CARD payments. We will process your insurance claim for our reimbursement if you provide us with the necessary insurance information.

Please inform our business office of any insurance changes, address changes and telephone changes.

1. Your insurance policy is a contract between you, your employer and the insurance company. We ARE NOT parties to that contract. Our relationship is with you, the patient, not your insurance company. However, we will bill your insurance company as a courtesy to you.

2. All charges are YOUR responsibility whether your insurance company pays or not. Most services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover, or cover at a lesser percentage.

3. Medicare patients without a secondary insurance and patients who do not have insurance will be asked to make partial payments at time of service.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our business office so that we can assist you in the management of your account. If a payment plan is needed or any other assistance required, please feel free to call our business office.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and welcome the opportunity to serve you.

Patient Signature________________________________ Date____________

Medical Billing Representative: Beth (775)689-9217

Medical Billing Representative: Valyre (775)689-9219

01/08/2015