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ALLIANCE CANCER CARE COLORADO *at Red Rocks*

Patient Name:

Prefers to be called: ______________________________

Date of Birth:

<u>Referring Physicians:</u>

Additional Physicians: ______________________ ______________________

Check if you have had: ☐ Previous Radiation ☐ Surgery ☐ Chemotherapy ☐ Hormone Therapy

If you have received radiation previously, when, where, and Physician:______________________

Reason you are being seen: ____

____

Past medical illnesses – Check if you have a history of any of the following:

☐ Scleroderma ☐ Lupus ☐ Ulcerative Colitis ☐ Connective Tissue Disease
☐ Crohn's Disease ☐ Tuberculosis ☐ High Blood Pressure ☐ Diabetes (IDOM/NIDOM)
☐ Heart Disease ☐ Heart Attack

List medical problems:____

____

____

List surgeries, hospitalizations, accidents and injuries:

Year	Description	Year	Description

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Medication History

Check here if you do not have any known drug allergies - ☐

Allergies – Check and describe your allergic reaction:

Shellfish: ☐ Yes ☐ No Reaction:___________________________

Iodine: ☐ Yes ☐ No Reaction:___________________________

Contrast Dye: ☐ Yes ☐ No Reaction:___________________________

Tape: ☐ Yes ☐ No Reaction:___________________________

Latex: ☐ Yes ☐ No Reaction:___________________________

Penicillin: ☐ Yes ☐ No Reaction:___________________________

Sulfa: ☐ Yes ☐ No Reaction: ___________________________

Other drug allergies: Name: ______________________ Reaction:___________________________

Name: ______________________ Reaction:___________________________

Name: ______________________ Reaction:___________________________

Name: ______________________ Reaction:___________________________

**** VERY IMPORTANT to List all Medications, Vitamins and Herbs. Please Include Dose:**

Medication	Dosage	Frequency	Route

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Social History

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Race: ______________________ Religion: ______________________

Persons living in my household: ______________________

Last school grade completed: ______________________

Education: ______________________

Occupation (s): ______________________

☐ Employed ☐ Unemployed ☐ Disabled

☐ Retired ? If yes, when did you retire? ______________________

Hobbies, Activities, Interests: ______________________

Tobacco History

Do you currently smoke: ☐ Yes ☐ No

If YES, how many packs per day? __________, for how many years? ________

If NO, did you smoke in the past? ☐ Yes ☐ No

When did you quit smoking? ______________________

Do you, or have you used other forms of tobacco (cigars, snuff, etc.)? ______________________

Alcohol History

Do you drink alcohol? ☐ Yes ☐ No

If YES, what type(s) of alcohol do you drink? ______________________

How often do you drink? ______________________

What amount do you drink? ______________________

Have you ever had a problem with alcohol abuse? ☐ Yes ☐ No

Infectious Disease History

Have you been exposed to HIV virus? ☐ Yes ☐ No

Have you ever had Hepatitis? ☐ Yes ☐ No

Have you engaged in high risk sexual activity? ☐ Yes ☐ No

Have you used intravenous drugs? ☐ Yes ☐ No

Have you been exposed to TB (Tuberculosis)? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes ☐ No

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Family History							
Family Member (list only biological) (If deceased, list age at death)	Age	Deceased	Cancer	Diabetes	High Blood Pressure	Heart Attack	Fill in other major health problems of family member. If deceased, fill in cause of death, include accidents and suicides.
Mother							
Father							
Sister and Brothers							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
Children							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							

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Review of Systems

Constitutional

☐ Unusual weight loss, amount ___________ ☐ Weight gain, amount _______________

☐ Fatigue ☐ Fever ☐ Chill ☐ Night sweats (requiring change of pajamas or sheets).

Blood Disorders

☐ Excessive bruising ☐ Frequent nosebleeds ☐ Gum bleeding ☐ Taking anticlotting drugs

☐ History of bleeding or clotting problems?

Endocrine

☐ Diabetes: ☐ Yes ☐ No If yes, do you require insulin? ☐ Yes ☐ No

☐ Thyroid problems (hyperthyroidism, goiter, hypothyroidism).

☐ Excessive hunger ☐ Excessive thirst ☐ Excessive urination ☐ Heat intolerance

Skin

☐ Rashes ☐ Severe itching ☐ Sores

Head and Neck

Eyes ☐ Glaucoma ☐ Cataracts ☐ Spots ☐ Double vision ☐ Flashing lights ☐ Dry eyes

☐ Glasses ☐ Contacts ☐ Recent Vision Change ☐ Excessive tearing

Ears ☐ Hearing Loss ☐ Ear ache ☐ Dizziness ☐ Ringing/Tinnitus ☐ Sensitivity to noise

Nose ☐ Sinus problems ☐ Frequent colds ☐ Hay fever ☐ Nasal stuffiness ☐ Runny nose

Mouth ☐ Sores ☐ Sore throat ☐ Sore tongue ☐ Dry mouth ☐ Speech problems ☐ Gum bleeding

☐ Denture: Upper _____ Lower _____ ☐ Partial plates: Upper _____ Lower _____

☐ Bridge: Upper _____ Lower ______

Throat ☐ Voice changes ☐ Fullness ☐ Stiffness ☐ Hoarseness ☐ Tenderness or pain

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Cardiovascular and Respiratory

☐ Angina ☐ Swollen feet ☐ Shortness of breath at rest ☐ Heart murmur ☐ Coughing up blood

☐ Chest pain ☐ Pleurisy ☐ Emphysema ☐ Congestive heart failure ☐ Asthma

☐ Bypass surgery ☐ Previous heart attack ☐ Blood clots ☐ Poor circulation ☐ High blood pressure

☐ Palpitations ☐ Rheumatic Fever ☐ Shortness of breath with activity ☐ Wheezing

☐ Chronic bronchitis ☐ History of TB (tuberculosis) ☐ Irregular heart beat/arrhythmia

☐ Oxygen? ________liters/minute ☐ Cough: Productive ____________ non-productive ___________

☐ Need to sleep with several pillows, otherwise patient becomes short of breath.

Gastrointestinal

☐ Loss of appetite	☐ Liver problems	☐ Regular use of antacids
☐ Constipation	☐ Tea colored urine	☐ Regular use of laxatives
☐ Jaundice	☐ Hemorrhoids	☐ Change in bowel habits
☐ Heartburn	☐ Blood in stools	☐ Pain upon swallowing
☐ Nausea	☐ Abdominal pain	☐ Gallbladder problems
☐ Vomiting	☐ Vomiting of blood	☐ Grayish colored stools
☐ Diarrhea	☐ History of hepatitis	☐ Difficulty swallowing
☐ Indigestion	☐ Black, tarry stools	☐ History of Crohn's disease
☐ Irritable bowel syndrome	☐ Change in color of the stool	☐ Change in shape of the stool
☐ History of ulcerative colitis	☐ Bright red blood from the rectum	

Genitourinary: Male

☐ Urgency ☐ Enlarged prostate ☐ Sores or discharge from penis ☐ Dribbling ☐ Poor urinary flow

☐ Pain or burning with urination ☐ Hernias ☐ Frequent urination

☐ History of bladder or urinary tract infection ☐ Flank pain ☐ Blood in urine

☐ Testicle pain or enlargement or lumps ☐ Kidney stones ☐ hesitancy upon urination

☐ Decreased force of stream ☐ Incontinence ☐ Not able to obtain erection sufficient for intercourse

☐ ________number of times you get up to urinate at night.

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Genitourinary: Female

☐ Dribbling ☐ Frequent urination ☐ Pain or burning with urination ☐ Kidney stones ☐ Blood in urine

☐ Frequent urinary tract infection ☐ Flank pain ☐ Incontinence of urine ☐ Bleeding between periods or after intercourse

_____age at onset of menstrual period ______date of last menstrual period ______number of miscarriages

_____number of pregnancies ______age at first delivery ______age at menopause

_____number of live births ______date of last PAP/pelvic exam ☐ Hormone replacement:____________

Musculoskeletal

☐ Scoliosis ☐ Osteoarthritis ☐ Weakness of arm(s) or leg(s) ☐ Bursitis ☐ Rheumatoid arthritis

☐ Muscle cramps or spasms ☐ Sciatica ☐ Pinched nerve ☐ Surgeries on muscles, joints or bones ☐ Gout

☐ Previous fractures ☐ Injuries to muscles or bones ☐ Tendonitis ☐ Chronic back pain ☐ Dislocations:__________

Neurologic

☐ Headaches ☐ Disorientation ☐ Change in vision ☐ Strokes ☐ Fainting ☐ Loss of coordination ☐ Seizures

☐ Paralysis ☐ Weakness of part of the body ☐ Dizziness ☐ Loss of memory

Have you ever fallen at home? ☐ Yes ☐ No How many times? ___________________

Reason why you fell? ☐ Tripped ☐ Lost balance ☐ Legs gave out ☐ Fainted ☐ don't know

Do you have problems walking ☐ Yes ☐ No Explain:____

Do you need a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches

Check if you have problems independently: ☐ Eating ☐ Bathing ☐ Dressing

Do you have the strength and endurance to perform these activities? ☐ Yes ☐ No

Have you ever had any: ☐ Physical Therapy ☐ Occupational Therapy

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Psychiatric

☐ Depression ☐ Manic depression ☐ Schizophrenia ☐ Nervousness ☐ Anxiety

☐ Other mental illness Obsessive-compulsive disorder

Do you have a personal concern about which you would like to talk to someone?____________________

Are you worried about how your spouse/children are adjusting?____________________

Are finances at a critical point?____________________

Do you feel stressed out and overwhelmed by the situation? ____________________

Would you like to meet with a chaplin?____________________

Is cancer causing you to rethink your priorities? ____________________

Check the description below if it describes you:

☐ Significant change in appetite
☐ Change in sex life
☐ Loss of interest in hobbies
☐ Feeling hopeless
☐ Change in sleeping patterns
☐ Increased use of alcohol
☐ Difficulty in controlling anger
☐ Tendency to isolate or withdraw
☐ Frequent crying spells
☐ Are you restless?
☐ Loss of interest in your job
☐ Difficulty concentrating
☐ Have you had a really good laugh in the past ten days?

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Patient name:

DOB:

__________ **Assignments of Benefits**: I authorize payment directly to Alliance Cancer Care at Red Rocks and Mountain Radiation Oncology Consultants, P.C., of all insurance or other health benefits to which I would otherwise be entitled for my entire course of medical care and services.

__________ **Release of Information**: I authorize release of necessary information from my medical record for the purpose of insurance claim payment(s), treatment authorizations, and my continuing medical care.

__________ **Financial Agreement**: I understand that I am responsible for and agree to pay all charges and/or expenses rendered which are not covered by my insurance and are deemed my responsibility per my insurance policy (co-pays, co-insurance, deductibles, out-of-pocket expenses, etc.).

__________ **Privacy Notice Acknowledgment**: I hereby acknowledge receipt of the Notice of Privacy Practices given to me by Alliance Cancer Care at Red Rocks. I not initialed, reason why acknowledgement was not obtained:

____

__________ **Consent to Leave Information**: I authorize Alliance Cancer Care at Red Rocks and Mountain Radiation Oncology Consultants, P.C. to release information regarding my care as follows:

Name of Primary Care
Provider:____

☐ Leave information on my voice mail answering machine on the following:
☐ Home ☐ Cell# ☐ Work# (listed on current demographic form)

☐ Leave information regarding my care and/or financial information with the following family members and/or individuals – not physicians or medical professionals.

Name: ____

Phone: ____

☐ **Emergency Contact:** Contact the following person in the case of an emergency only:

Name: ____

Phone: ____

____ Date ______________________

Signature of Patient/Guardian/Representative

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Instructions to Patient

1. Please fully complete, sign and date this form.
2. Please return this form to the Alliance location where services are performed.

I, ____, acknowledge that I have received the Notice of Privacy Practices issued by Alliance HealthCare Services or one of its subsidiaries of affiliates (collectively, "Alliance"). I agree that I will contact Alliance's Privacy Official with any questions that I may have concerning the Notice of Privacy Practices.

____ __________________________

Signature of Patient Date

In the event the patient declines acknowledgement of receipt of Alliance's Notice of Practices, Please describe below the good faith efforts used to obtain such acknowledgement and the reason why the acknowledgement was not obtained:

____
____
____
____

Signature: ____________________________________

Name: ____________________________________

Title: ____________________________________

Date: ____________________________________

Instructions to Service Location

After completion, please return this form to the applicable Centralized Billing Office (i.e., Canton or Andover office) for processing.

NOTICE OF PRIVACY PRACTICES

POLICY

Patients have the right to receive a summary of the routine and potential uses and disclosures of their Protected Health Information ("**PHI**") that may be made by Alliance HealthCare Services ("Alliance") or by Alliance's business partners. They must also be informed of their privacy rights and of Alliance's legal duties with respect to PHI.

As a covered entity, Alliance is required by the U.S. Department of Health and Human Services to prepare a Notice of Privacy Practices ("**NPP**") for Alliance's retail and Alliance Network ("**AIN**") patients (Attachment A005). The NPP documents Alliance's privacy policies and practices as well as patient rights related to the use and disclosure of PHI.

It is the policy of Alliance that all Team Members and other Alliance workforce members adhere to Alliance's NPP. Furthermore, it is the policy of Alliance that all retail and AIN patients are informed of and have the opportunity to obtain a printed copy of Alliance's NPP.

Alliance is required to make a good faith effort to obtain written acknowledgement of receipt of Alliance's NPP from retail and AIN patients, and, if not obtained, to document its good faith efforts to obtain such acknowledgement and the reason why the acknowledgement was not obtained. A copy of Alliance's NPP may be provided to wholesale patients; however, Alliance is not necessarily required to offer it or to obtain their acknowledgement.

SCOPE

This Policy applies to Alliance Team Members and other Alliance workforce members (i.e., volunteers, trainees, and other non-employees whose conduct, in the performance of work for Alliance, is under the direct control of Alliance, whether or not they are paid by Alliance) having access to any PHI of retail or AIN patients (see Policy 10001, PHI). Wholesale clients are required to inform their (wholesale) patients about the provisions of their (the wholesale client's) NPP and to make good faith efforts to obtain the patient's acknowledgement of receipt of their NPP, and, if not obtained, to document its good faith efforts to obtain such acknowledgement and the reason why the acknowledge was not obtained. In meeting their own HIPAA responsibilities, however, the wholesale client may opt to request that Alliance, as their business associate, assist with these processes.

GUIDELINES

General

I. Alliance will maintain a single version of its NPP throughout Alliance and affiliated entities for which Alliance has HIPAA regulatory compliance responsibility. It is likely that, while the content of the NPP is standardized, the NPP related to some entities (i.e. managed, joint ventures, etc.) may include the entity's unique name and logo rather than those of Alliance.

II. At locations where retail or AIN services are provided, Alliance's NPP must be posted in a clear and prominent location where it is reasonable to expect individuals seeking service to be able to read the NPP. Production of a standard "posted" version of Alliance's NPP will

be coordinated by the Alliance Privacy Official. It is recommended that Alliance's NPP be mounted on a wall within the unit itself for retail/AIN mobile sites and in waiting areas at retail/AIN fixed sites. It is required that the NPP posting location be accessible to patients over the course of their procedure or visit.

III. Printed versions of Alliance's NPP must be available at the retail/AIN service delivery sites so that, if interested, patients may receive a printed copy to take with them. Alliance is required by the U.S. Department of Health and Human Services ("HHS") regulations to inform retail and AIN patients of the existence of Alliance's NPP and to offer a printed copy to them. Unless these requirements are introduced by wholesale clients and accepted by Alliance, as their business associate, then Alliance is NOT required to follow this process for wholesale patients.

IV. The most current version of Alliance's NPP will be posted and maintained on the Alliance external website. It will also be posted, with appropriate naming changes, on the external websites of affiliates for which Alliance has compliance responsibility.

V. Questions regarding Alliance's NPP and/or any of its provisions should be directed to the Alliance Privacy Official at the telephone number or email provided on the NPP.

Specific Requirements for Retail and AIN Only

VI. Alliance's NPP must be specifically referred to and a printed copy offered to retail and AIN patients:

1. No later than the date of the first service delivery; or
2. In an emergency treatment situation, as soon as reasonably practical after the emergency treatment situation.

VII. Except in emergency treatment situations, site staff must make a "good faith effort" to obtain a written acknowledgment of receipt of the NPP using an Acknowledgment of Receipt of Notice of Privacy Practices form (Attachment A011), and if not obtained, document on such form the staff's good faith efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained.

VIII. Whenever acknowledgment of receipt of Alliance's NPP is required (i.e., retail and AIN health care services), the completed and signed Acknowledgment of Receipt of Notice of Privacy Practices form must be forwarded along with other health care service paperwork to the applicable Centralized Billing Office (i.e., Canton or Andover office) for retention.

Revision of the NPP

IX. Alliance's NPP may only be modified by agreement of the Alliance Privacy Official. All requests for changes should be directed to Alliance's Privacy Official at the Resource Center. The modified NPP must include an effective date that may not be earlier than the date on which the notice is printed or otherwise published.

X. When revised and upon the specified effective date, only the current version of the NPP should be used throughout Alliance. (Maintaining sufficient inventories of the most current version of the NPP is the responsibility of Operations.) Operations hold the responsibility to distribute and post the revised NPP at each site in advance of the revision effective date. On the effective date of the revision, the new version will be posted on the Alliance and affiliate external websites. Previously posted and printed versions of the NPP should be removed on the effective date of the new version.

XI. Alliance must document compliance with this Policy by retaining copies of each version of NPP issued by Alliance, and each completed Acknowledgment of Receipt of Notice of Privacy Practices signed by the patient or the Alliance staff member, as applicable, for the longest of: (i) 6 years from the date of its creation; (ii) 6 years from the last effective date of the relevant documents; or (iii) as specified in Alliance's Records Retention Policy. All such documentation shall be maintained with the patient file.

COMPLIANCE

Violation of this Policy may result in disciplinary action, counseling and/or termination.