Cypress Hematology & Oncology

INITIAL VISIT EVALUATION

Name:_____ **Date of Birth:**_____

Who referred you:_____ **Date of visit:**_____

Reason for visit: _____

Health care providers you would like us to send correspondence to:

Please list all questions you would like to be addressed today:

Please check if you have any of the conditions listed below:

_____ Blood clots
_____ Cancer: Type _____
_____ Hypertension
_____ Heart disease
_____ Arrhythmia
_____ Angina
_____ Diabetes
_____ Hypothyroidism
_____ Hyperthyroidism
_____ Peptic ulcer
_____ GERD
_____ Bleeding
_____ GI bleed
_____ Pneumonia
_____ COPD
_____ Emphysema
_____ Urinary tract infection
_____ Rheumatoid arthritis
_____ Osteoarthritis
_____ Osteopenia/Osteoporosis
_____ Stroke

Please list all surgeries you had and year of surgery:

For Women:

Age at first menstrual cycle:_____
Date of last menstrual period: _____
Age at menopause: _____
Number of pregnancies: _____ deliveries_____ abortions_____
Miscarriages_____

Family History:

	Age	Any Illness
Father:	_____	_____
Mother:	_____	_____
Sons:	_____	_____
Daughters:	_____	_____

Any family members who has a diagnosis of cancer: _____

Type: _____

Social History:

Married _____ Single _____ Divorced _____ Widowed _____

What kind of work do you do? _____

	YES	NO	
Chemical exposure	_____	_____	
Smoking history	_____	_____	How much do you smoke? _____
			For how many years? _____
Alcohol intake	_____	_____	How much? _____

Please list all Allergies and reaction:

_____

_____

Please list all Medications you are taking. Include dose, route & frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Review of symptoms:

Please check if you have any of these symptoms:

_____ weight loss
_____ fever
_____ nausea
_____ vomiting
_____ night sweats
_____ headache
_____ blurred vision
_____ sore throat
_____ difficulty breathing
_____ cough
_____ bloody sputum
_____ chest pain
_____ palpitations
_____ difficulty swallowing
_____ pain with swallowing
_____ abdominal pain
_____ diarrhea
_____ constipation
_____ bloody stools
_____ bloody urine
_____ vaginal bleeding
_____ burning with urination
_____ swelling of lower extremities
_____ dizziness
_____ difficulty walking
_____ weakness of extremities

Centura Health.

Consent for Medical Treatment
PGCT-001 rev. 12/11

Patient Label

1 **CONSENT FOR HEALTH CARE SERVICES.** I authorize physician(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Centura Health practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Centura Health practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice.

2 **NON-CENTURA PRACTITIONERS.** I understand that I may receive services from professionals who provide care to me who are not employees or agents of a Centura Health practice. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from the Centura Health practice. **I understand that, in some cases, these non-Centura professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

3 **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice of my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4 **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due to payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

Patient Label

5 **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6 **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

7 **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgement in no way affects the care I shall receive at the Hospital.

By checking on of the boxes below, I acknowledge:

☐ **I have been offered or accepted a copy of the Notice of Privacy Practices**
☐ **I declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT

Cypress
HEMATOLOGY
& ONCOLOGY

Nadine Mikhaeel, MD
Thomas Kenney, MD
Todd F. Capizzi, MD

Leslie Hinds, MS, RN, NP-C
Carolyn Becker, MS, RN, AOCN, APN

Dear Patients,

Cypress Hematology and Oncology would like to welcome those of you who have just joined us and those of you who have been our long standing patients.

Our number one concern is for the care, health and welfare of all our patients. Cypress Hematology and Oncology has grown to the point that we feel the need to let you know what you can expect from us and what we expect from you.

What to expect from us/from you.

1: We strive to call each patient back before the end of each day unless you are having concerning questionable urgent symptoms. (As a reminder, if you have a life threatening emergency please dial 911). Our daily schedules are often full and we are not able to return a call until the end of the workday.

2: We need all of you to sign in at the front desk so we can check you in appropriately and route your chart to the appropriate provider or nurse.

3: Our policy states that you must give us 24 hours to refill prescriptions that need to be written such as narcotic or any controlled substance. Please plan ahead and know when you are about to run out of your prescription. To make sure that you are not without your prescription, count your pills and call us when you have a one week supply left. Again, please give us 24 hours.

4: We ask that you have an appointment each time you need lab tests. When scheduling your blood work please keep in mind that our Medical Assistants go to lunch from 12:00 pm to 1:00 pm.

Thank you for your anticipated cooperation and consideration.

Bonnie Peistrup

Practice Manager

Plea. RINT and COMPLETE AL ctions below!

Date _____

PATIENT REGISTRATION/INFORMATION

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____
last name first name initial

How do you wish to be addressed? _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Street Address: _____ (Apt # _____) City: _____ State: _____ Zip: _____

Best Phone: (____)_____ Work Phone: (____)_____ Other Phone: (____)_____

Occupation:_____ Employer/Name of School: _____

e-mail_____Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Student ☐Retired

NEXT OF KIN

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Other Phone #: _____

RELEASE OF HEALTH/BILLING CONSENT (Must be signed to be valid)

I give my permission for the following persons to speak with Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Todd Capizzi and associates of Cypress Hematology & Oncology regarding my ***Health/Billing Information:***

1) _____ Relationship: _____ 2) _____ Relationship: _____

Signature: _____ Date: _____

PATIENT INSURANCE INFORMATION (Please present insurance cards to receptionist)

Primary Insurance Company's Name: _____ ID #: _____

Group #: _____ Co-pay Amount: _____ Effective Date: _____

Subscriber's Name: _____ SS #: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ ID #: _____

Group #: _____ Co-pay Amount: _____ Effective Date: _____

Subscriber's Name: _____ SS #: _____ DOB: _____ Relationship to Patient: _____

REFERRING PHYSICIAN AND YOUR PRIMARY CARE PHYSICIAN

Referred By: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

EMERGENCY CONTACT (In Case of Emergency)

Name: _____ Relationship: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

I understand and acknowledge that my insurance coverage is a contract between my insurance company and myself and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Todd Capizzi and associates of Cypress Hematology & Oncology. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or a HMO I am required to make my co-pay at the time of service and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current.

I authorize Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Todd Capizzi and associates of Cypress Hematology & Oncology to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Todd Capizzi and associates. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or responsible party: _____ Date: _____

Centura Health® Page 1 of 1

Patient Authorization to Disclose Protected Health Information
#CHCR-004 rev. 09/11

Patient Label

AUTHPHI

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	City, State, Zip Code	Telephone Number

I hereby authorize the Centura facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by: Cypress Hematology and Oncology
Centura Facility
2555 S DOWNING ST, STE 240
Address
DENVER CO 80210
City, State, Zip Code

Release to: _____
Organization, Agency, Individual
_____
Attn:
_____
Address
_____
City, State, Zip Code

Treatment Date(s): _____
Purpose: ☑ Further Medical Care ☐ Workers' Comp
☐ Personal Use ☐ Insurance ☐ Legal
☐ Marketing/Fundraising
☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☐ Mail records directly to address above
☐ Call to pick-up records: _____
☑ Fax records to: _____

Pertinent Protected Health Information Allowed to be Included:

☐ Discharge Summary	☐ Radiology	☐ Special Studies	☑ Entire Medical Record
☐ History & Physical/Consult	☐ Output Record	☐ Medication Records	
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records	
☐ Labs	☐ Physician Orders	☐ Other (specify): _____	

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if applicable: I understand that Centura Health ☐ will ☐ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Legal Guardian)

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate

Name of individual signing on behalf of patient: _____

Verification: ☐ Drivers License # _____ ☐ Other Appropriate ID: _____

OFFICE USE ONLY: Attach copies of required identification.

Number of pages released: _____ Completion date: _____ Delivery method: _____

Name of individual who received request: _____ Date received: _____

Patient Medical Record Number / Account Number: _____ / _____

RELEASE OF INFORMATION CONSENT FORM

I hereby authorize _____
(your doctor's name or office name - please include all)

to release the following medical records:

_____All Medical Records
_____History & Physical
_____Procedure Reports
_____Discharge Summary
_____X-Ray Reports
_____Consultation Reports
_____X-Ray Films
_____Estrogen/Progesterone Receptor Reports
_____Other: _____

_____Operative Reports
_____Laboratory Test Reports
_____Pathology Reports
_____Radiation Therapy Treatment
_____Pathology Slides
_____Physician Progress Notes
_____Chemotherapy Records

_____

TO: CYPRESS HEMATOLOGY & ONCOLOGY
Nadine Mikhaeel, M.D. Thomas Kenney, M.D. Todd Capizzi, M.D.

Porter Adventist Hospital Office
2555 S. Downing St., Suite 240
Denver, CO 80210
Phone: (303)-715-7030
Fax: (303)-715-7035

and

Parker Adventist Hospital Office
9399 Crown Crest Blvd., Suite 215
Parker, CO. 80138
Phone: (303) 269-4420
Fax: (303) 269-4439

Patient Name: _____ DOB: _____

Signature of Patient: _____

Date Signed: _____

Signature of Witness: _____

Date Witnessed: _____

Nutrition Screen (adapted from the PG-SGA)

Please fill out this form to the best of your ability. The information will help us determine if you are having any eating difficulties. Our dietitian will be available to you during and after your cancer treatment to help you address these symptoms or any other questions you may have. This is a free service offered to our patients.

1. **What type of cancer are you being treated for?** _____

2. **Would you like to be contacted by the dietitian if you are screened at risk?** ☐ Yes ☐ No

3. Weight

I currently weigh about _____ pounds

I am about _____ feet_____inches tall

One month ago I weighed about _____ pounds

Six months ago I weighed about _____ pounds

Have you lost weight intentionally? ☐ Yes ☐ No

During the past two weeks my weight has:

☐ Decreased (1) ☐ not changed (0) ☐ increased (0)

4. Food Intake: As compared to my normal intake, I would rate my food intake during the past month as:

☐ Unchanged (0)
☐ more than usual (0)
☐ less than usual (1)

I am now taking:

☐ *normal food* but less than normal amount (1)
☐ little solid food (2)
☐ only liquids (3)
☐ only nutritional supplements (3)
☐ very little of anything (4)
☐ only tube feeding or only nutrition by vein (4)

5. Symptoms: I have had the following problems that have kept me from eating enough during the past two weeks (check all that apply):

☐ no problems eating (0)
☐ no appetite, just did not feel like eating (3)
☐ nausea (1) ☐ vomiting (3)
☐ constipation (1) ☐ diarrhea (3)
☐ mouth sores (2) ☐ dry mouth (1)
☐ things taste funny or have no taste (1)
☐ smells bother me (1) ☐ problems swallowing (2)
☐ feel full quickly (1)
☐ pain; where? (3) _____
☐ other** (1) _____

**Examples: depression, money, dental issues

6. Activities and Function: Over the past month, I would generally rate my activity as:

☐ Normal with no limitations (0)

☐ Not my normal self, but able to be up and about with fairly normal activities (1)

☐ Not feeling up to most things, but in bed or chair less than half the day (2)

☐ Able to do little activity and spend most of the day in bed or chair (3)

☐ Pretty much bedridden, rarely out of bed (3)

OFFICE

OFFICE STAFF: please deliver this form to the dietitian, either by fax (303-778-5293), secured scanned email (amberthomas@centura.org), or in person (drop box in office of radiation oncology)

PLACE PT LABEL HERE

RD USE

Date received _____ Patient Score (combined_____ % wt chg 1 month ____ % wt chg 6 months ____

1 month % change: ☐ 0-1.9 (0) ☐ 2-2.9 (1) ☐ 3-4.9 (2) ☐ 5-9.9 (3) ☐ ≥ 10 (4)

6 month % change: ☐ 0-1.9 (0) ☐ 2-5.9 (1) ☐ 6-9.9 (2) ☐ 10-19.9 (3) ☐ ≥ 20 (4)

Patient risk level (based on combined scores): ☐ minimal risk (0-7 pnts) ☐ at risk (8+ pnts)

Patients screened at risk will be contacted within 5 business days by the dietitian to schedule an appointment if desired