High Plains Oncology

REGISTRATION FORM

Primary Care Physician: _____ Today's Date: _____

Preferred Pharmacy: _____

PATIENT INFORMATION

Patient Name:_____ Birth Date:_____ Age: _____

Is this your legal name? ☐ Y ☐ N If not, what is legal name? _____

Gender: ☐ M ☐ F Race:_____ Marital status: (circle) Single / Married / Div / Sep / Widow

Social Security No.:_____ Home Phone: _____

Cell Phone: _____ Email:_____

Address/P.O. Box: _____ City: _____ State:_____ Zip:_____

Occupation: _____ Employer: _____

Employer Phone No:_____ Status: ☐ Full ☐ Part ☐ Unemployed ☐ Retired ☐ Disabled

Referring Doctor (name & phone): _____

Emergency Contact Name:_____ Relationship to Patient:_____

Phone #:_____ Address:_____ City/St:_____ Zip:_____

INSURANCE INFORMATION

Primary Ins Co: _____

Ins Co Address:_____

Policy Holder Name:_____

Policy Hldr Sex: ☐ M ☐ F Policy Hldr DOB:_____

Member ID#:_____

Relationship to Patient:_____

Group/Policy#:_____

Employer:_____

Secondary Ins Co:_____

Ins Co Address:_____

Policy Holder Name:_____

Policy Hldr Sex: ☐ M ☐ F Policy Hldr DOB:_____

Member ID#:_____

Relationship to Patient:_____

Group/Policy#:_____

Employer:_____

AUTHORIZATION, ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance company to pay HIGH PLAINS ONCOLOGY all medical benefits. I understand that ultimately I am responsible for all charges not covered by my insurance as well as all deductibles, co-insurance, and co-pay amounts as determined by my insurance company. It is my responsibility to notify this clinic of any change in my healthcare coverage. I also understand I will be responsible for all collection fees and all 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.

Patient/Guardian Signature:_____ **Date:**_____

Original Date:	
Date Revised:	

High Plains Oncology

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*				☐ M ☐ F	**DOB:**	
Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Partnered	☐ Widowed
Primary Care Physician:				**Other Physicians:**		

PERSONAL HEALTH HISTORY

Please complete for any PRIOR cancer, radiation treatment, or chemotherapy		
Prior Cancers:	☐ Yes ☐ No ☐ Don't Know	If yes: Year_____ Kind of Cancer_____
Prior Radiation Treatment:	☐ Yes ☐ No ☐ Don't Know	If yes: Year_____ Area Treated_____ Where_____
Prior or Current Chemotherapy:	☐ Yes ☐ No ☐ Don't Know	If yes: Year_____ Where_____

Surgeries

Date	Type of Operation	Hospital

Other hospitalizations

Date	Reason	Hospital

Are you on a clinical trial/experimental drug?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, including vitamins and inhalers				
Name of Drug	Dose	Frequency Taken	Length of time taken	Reason for taking
Pharmacy Name:_____			Pharmacy Phone Number:_____	

Allergies to medications / food / other	
Name the Drug/substance	Reaction You Had

SOCIAL HISTORY AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Work	Current Occupation:		# of years_____	
	Previous Occupation:		# of years_____	
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?	For how many years?		
	If you have quit drinking, how old were you when you quit? _____ years old			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or if quit: Year started_____	Year quit_____	
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?		☐ Yes	☐ No
	Do you have a Medical Power of Attorney for Health Care?	☐ Yes ☐ No	That person is:_____	
	Did you bring either of these with you?	☐ Yes ☐ No ☐ N/A	(If yes, copy in chart) Initials_____	
	Do you want assistance in completing an Advanced Directive or Medical Power of Attorney?		☐ Yes	☐ No

ARE YOU TAKING:		
Glucophage / Metaformin?	☐ Yes	☐ No
Coumadin / Warfarin?	☐ Yes	☐ No
Aspirin / Non-Steroidal Anti-Inflammatory?	☐ Yes	☐ No

Please turn to next page

FAMILY HISTORY OF CANCER

	AGE DIAGNOSED	TYPE OR LOCATION OF CANCER		AGE DIAGNOSED	TYPE OR LOCATION OF CANCER
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

REVIEW OF SYMPTOMS

HAVE YOU DEVELOPED ANY OF THESE SYMPTOMS IN THE PAST YEAR:

Fever	☐	Yes	☐	No	Nausea	☐ Yes	☐ No
Weight Loss	☐	Yes	☐	No	Decreased Appetite	☐ Yes	☐ No
Depressed	☐	Yes	☐	No	Bone Pain	☐ Yes	☐ No
Tired	☐	Yes	☐	No	Back Pain	☐ Yes	☐ No
Numbness / Tingling	☐	Yes	☐	No	Blurred / Double Vision	☐ Yes	☐ No
Headache	☐	Yes	☐	No	Hoarseness	☐ Yes	☐ No
Easy Bruising	☐	Yes	☐	No	Shortness of Breath	☐ Yes	☐ No
Swollen Glands	☐	Yes	☐	No	Cough	☐ Yes	☐ No
Chest Pain	☐	Yes	☐	No	Other:_____	☐ Yes	☐ No

PAIN

Are you having any pain or discomfort?					☐ Yes	☐ No
Indicate how much pain by circling a number: **NO PAIN** 1 2 3 4 5 6 7 8 9 **SEVERE PAIN**						
Where is your pain?						
Describe your pain:	☐ Achy	☐ Burning	☐ Dull	☐ Stabbing	☐ Sharp	☐ Other:_____
What makes your pain better?						
What makes your pain worse?						
Amount of pain medication in a 24 hr period?						

PAST MEDICAL HISTORY

Check if you have, or have had, any of these diagnoses:

☐ High Blood Pressure	☐ Emphysema or COPD	☐ Lupus, Scleroderma, or collagen vascular disease
☐ Heart Disease	☐ Diverticulitis	☐ Liver Disease
☐ Pacemaker	☐ Thyroid Disease	☐ Tuberculosis
☐ Diabetes or sugar in urine	☐ Kidney loss, dysfunction, or abnormality	☐ Hysterectomy
☐ Seizures	☐ Crohn's Disease or ulcerative colitis	☐ Post-Menopausal
☐ Stroke	☐ Could you be Pregnant	☐ Lactating
☐ Anemia	Last Menstral Period _____	☐ Other:_____

Patient Record Disclosures

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE MARK ALL THAT APPLY):

☐ Home telephone:_____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call-back number only
- ☐ Please **DO NOT** leave a message

☐ Work Telephone:_____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call-back number only
- ☐ Please **DO NOT** leave a message

☐ Cell Number:_____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call-back number only
- ☐ Please **DO NOT** leave a message

☐ Fax Number:_____
- ☐ Please **DO NOT** fax any information to me

☐ Written Communication
- ☐ Mail to my home address
- ☐ Mail to my work address
- ☐ Please DO NOT mail

☐ The following people may have access to my medical information (PHI):
- ☐ Spouse/Sig. Other: _____
- ☐ Child:_____
- ☐ Child:_____
- ☐ Child:_____
- ☐ Other:_____
- ☐ Nobody should have access

☐ Email:_____
- ☐ Please **DO NOT** email me

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

High Plains Oncology
5916 N. Lovington Hwy
Hobbs, NM 88240
Ph: (575)942-2550
Fax: (575)942-2551

ATTN: Medical Records

Medical Records Request Form

Please release all medical records from to Dr. with High Plains Oncology.

Patient Name:

Patient DOB:

Patients Address:

Please Send:

☐ Demographics/Face Sheet	☐ Insurance	☐ Op Report
☐ Lab (Most Recent)	☐ Consult	☐ Pathology
☐ Diagnostic Imaging	☐ Last Visit	☐ Treatment Summary

Comments:

Privacy Notice Acknowledgement

I have reviewed High Plains Oncology's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

WHO DOES THIS NOTICE APPLY TO?

High Plains Oncology provides health care to our patients and clients in partnership with other professionals and organizations. The privacy practices in this notice will be followed by:

- Any High Plains Oncology ("the center") health care professional authorized to enter information into your chart.
- All departments and units of this center.
- Any member of a volunteer group that is authorized by this center to help you.
- All employees, staff and other personnel of the center. Any business associate with whom we share health information.

OUR RESPONSIBILITY TO YOU REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you is personal. We are committed to protecting the privacy of medical information about you. In an effort to provide the highest quality medical care and to comply with certain legal requirements, we will and are required to:

- Keep your medical information private.
- Provide you with a copy of this notice.
- Follow the terms of this notice.
- Notify you if we are unable to agree to a restriction that you have requested.
- Accommodate reasonable requests by you for us to communicate health information by alternative means or at alternative locations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose medical information about you for your **treatment** (such as sending medical information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as comparing patient data to improved treatment methods).

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (TPO)

We will use your health information for treatment. For example: Information received by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine your course of treatment. We will also provide your physician or a subsequent healthcare provider with copies of reports to assist him or her in treating you once you're discharged.

We will use your health information for payment. For example: A bill may be sent to you or an insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used in your treatment.

We will use your health information for regular health care operations. For example: Members of the medical staff, the risk or quality management staff of the center may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

HOW WILL MY INFORMATION BE USED

- We may contact you for **appointment reminders,** or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you.
- We may contact you to solicit support for certain **fundraising activities** . ***You will have an opportunity to refuse or opt-out of receiving this information upon the first contact by us*****.**

This information may be provided to members of the clergy, and except for religious affiliation, to other people who ask for you by name to include members of the media. ***If you would like to opt-out of being in the directory, please notify the admission staff*****.**

- Family and Friends. We may release medical information about you to a family member, friend, or any other person involved in your medical care. We may also give information to those you identified as responsible for payment of your care.

We may use or disclose medical information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without your prior authorization for the following purposes:

- Research . We may use and disclose medical information about you for research purposes. All research projects are subject to a special approval process through the appropriate committee.
- Law. We may disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.
- Public health. We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc. as required by law.
- Business associates. There are some services provided in our organization through contracts with business associates (ie. we may disclose medical information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the health care services we provide). To protect your health information we require the business associate to appropriately safeguard your information.
- Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
- Funeral directors. We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.
- Organ donation. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities for the purpose of tissue donation and transplant.
- Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events.
- Workers' Compensation. We may disclose health information necessary to comply with laws relating to Workers' Compensation or other similar programs established by law.
- Correctional institution. Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of other individuals.
- State Requirements. Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.
- Organized Health Care Arrangements. The center and its medical staff members have organized and are jointly presenting this notice to you. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment this time.

OTHER USES OF MEDICAL INFORMATION

In any other situation not covered by this notice, we will ask you for your written authorization before using or disclosing medical information about you. If you choose to authorize us to use or disclose your health information, you can later revoke that authorization by notifying us in writing of your decision, except to the extent that action has already been taken by us upon an authorization given to us.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although your health record is the property of High Plains Oncology that created it, you have the right to:

- Request a restriction, in writing*, on certain uses or disclosures of your medical information for treatment, payment or health care operations, with the exception of emergency situations. We will consider your request **, but we are not legally required to agree to a requested restriction.** We will inform you of our decision on your request.

- Obtain a paper copy of this notice of our privacy practices upon request.

- Inspect and obtain a copy of your medical information, in most cases.

- Request in writing*, an amendment to your records if you believe the information in your record is incorrect or important information is missing. We could deny your request to amend a record if the information was not created by us, maintained by us, or if we determine the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

- Obtain an accounting of disclosures stating who and where your health information has been disclosed for purposes other than treatment, payment, health care operations or where you specifically authorized a use or disclosure in the past six (6) years, but not prior to April 14, 2003. The request must be in writing and state the time period desired for the accounting*. After the first request, there may be a charge.

- Request that medical information about you be communicated to you in a confidential way or at an alternative location but you must specify how or where you wish to be contacted.

*All written requests or appeals should be submitted to our Privacy Official listed at the bottom of this notice.

CHANGES TO THIS NOTICE

The center has the right to change this notice at any time. We have the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the center. The notice will contain the effective date. In addition, you may request a copy of the current notice each time you register for treatment or health care services.

COMPLAINTS

If you have questions or would like additional information, or if you believe your privacy rights have been violated, you can contact the High Plains Oncology Privacy Officer via mail or call 575/942-2550. You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S. W., Washington, DC 20201. Filing a complaint will not negatively affect the treatment or coverage that you receive.

PRIVACY OFFICIAL

(575) 942-2550
5916 N. Lovington Hwy.
Hobbs, NM 88240

Notice of Privacy Practice

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

High Plains Oncology

FINANCIAL POLICY

Thank you for choosing High Plains Oncology to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

All new patients must complete our Patient Registration form as well as our Financial Policy before seeing the physician.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.

PAYMENT PLANS ARE ACCEPTED UPON APPROVAL.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by High Plains Oncology. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account at 877-301-7064.

All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes, it is your responsibility to notify our office of the change. If your insurance coverage changes to a plan where we are not participating or preferred providers, refer to the above paragraph. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

USUAL AND CUSTOMARY: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICAL NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you, is unnecessary, you will be responsible for the bill.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling 877-301-7064.
If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

High Plains Oncology

Office Practices

Mission ● The mission of High Plains Oncology is to provide contemporary radiation oncology services to the patients in Hobbs and the surrounding communities. We are committed to providing high quality, cost effective care and strive to be a source of continuing support to our patients and their families.

Office Hours ● High Plains Oncology hours are 8:00am-12:00pm and 1:00pm-5:00pm Monday-Friday. For after hours care, please call (575) 942-2550 and listen for your selection.

Non-Discrimination Statement ● Admission to High Plains Oncology is non-discriminatory for services rendered, regardless of age, race, religion, color, national origin, sex, or disability. All patients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

Referrals ● Some insurance plans require referrals. Notify your primary care physician that you will be receiving radiation therapy treatments. Be sure to verify that our physician is in your network. Going outside your network may cause you to take on large financial risks.

Insurance ● High Plains Oncology accepts most major insurance policies, private payment, and Visa & MasterCard. We will file all insurance claims releasing protected health information, provided we have the complete and accurate information, including your signature on file. Remember, insurance is a contract between you and your insurance company and is not a substitute for payment.

Co-Pays ● For your initial visit, a consultation charge will be billed. If you have a co-payment for office visits, a co-payment will apply. Please pay your co-payment at the time of your visit. Some patients have co-payments/co-ins per date of treatment. Please contact your insurance to verify if you have any questions regarding co-payments. These additional co-payments will be billed to you after your insurance company processes the claim. We will send out statements monthly.

Service Date ● These are a number of services that do not require the presence of the patient. You may notice billing dates on your invoice that you know you were not in the clinic. Typically, computer planning, dose calculations, and physics checks do not require the patients to be in the department. Due to insurance regulations, we must bill these services that date they are rendered.

Charges ● All of your charges (both the professional and technical portion) for your radiation therapy will be billed under the group name High Plains Radiation Investments, LLC by Radiation Management Services at the end of your course of treatment. The charges for services are based on the complexity and duration of services. The therapy center is a freestanding clinic and for insurance purposes is considered a Doctor's office. Dues to HIPAA guidelines for electronic submission of all charges, we work with a billing company to process our charges electronically and post payments to your account called Radiation Management Services. If you have questions concerning you bill, you can call (806) 796-1122 or toll free (877) 301-7064