OCROC
ORANGE COUNTY
RADIATION ONCOLOGY CENTER

Patient Registration

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street City State ZIP

Male ____ Female ____ Marital Status: (Circle) S M D W
Optional

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Name of referring doctor: _____ Phone: _____

Name of primary care doctor: _____ Phone: _____

Attention: We will use the address above and all phone numbers listed to contact you, mail, text and/or leave messages regarding your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.

Are you a patient in a skilled nursing home? Yes ____ No ___ If yes, where: _____

Employed: Yes ___ No ___ Employer Name: _____ Occupation: _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Spoken Language: _____ Preferred Language: _____

Additional Contact: _____ Relation: _____ Phone: _____

Guarantor Name: _____ Relationship to Patient: _____
Person responsible for payment if other than patient

Address: _____ Phone#: _____

Primary Insurance Information

Name of Insurance: _____ Subscriber: _____

Member ID#: _____ Group #: _____ Effective Date: _____

Secondary Insurance Information

Name of Insurance: _____ Subscriber: _____

Member ID#: _____ Group #: _____ Effective Date: _____

_____ _____
Signature of patient or representative Date

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PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **DOB:** _____/_____/_____

PREVIOUS SURGERIES

TYPE	DATE
_____	_____
_____	_____
_____	_____

DO YOU HAVE THE FOLLOWING? (PLEASE CIRCLE)

HEART PROBLEMS	YES	NO
PULMONARY DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
DIABETES	YES	NO
PREVIOUS STROKES	YES	NO

OTHER (PLEASE DESCRIBE)

_____
_____
_____

ALLERGIC TO MEDICATION? (IF YES, PLEASE LIST) YES NO

MEDICATION AND TYPES OF REACTION (RASH, SWELLING, ETC)

_____
_____
_____

FAMILY HISTORY OF CANCER? ("P" FOR FATHER OR "M" FOR MOTHER SIDE)

TYPE OF CANCER	HOW RELATED	(CIRCLE ONE) "P"	
EXAMPLE: LUNG CA	UNCLE		
_____	_____	P	M
_____	_____	P	M
_____	_____	P	M
_____	_____	P	M

SMOKING HISTORY? YES_____ NO_____

CIGARETTES: NUMBER OF PACKS PER DAY? _____

FOR HOW MANY YEARS? _____

IF QUIT SMOKING, FOR HOW MANY YEARS? _____

ALCOHOL CONSUMPTION? YES_____ NO_____

DAILY_____ WEEKLY_____ MONTHLY_____ OCCASIONALLY _____

SOCIAL HISTORY:

PLACE OF BIRTH _____

OF YEARS IN CALIFORNIA _____ # OF YEARS IN ORANGE COUNTY _____

OCCUPATION: _____

OF CHILDREN _____ # OF SIBLINGS _____

HOBBIES _____

CURRENT MEDICATION (PLEASE LIST MEDICATIONS YOU ARE NOW TAKING):

_____ _____ _____

_____ _____ _____

_____ _____ _____

HAVE YOU HAD A SEASONAL FLU SHOT? IF YES, WHEN? _____ NO_____

HAVE YOU HAD A COLONOSCOPY, FLEXIBLE SIGMOIDOSCOPY OR FECAL OCCULT BLOOD TEST? IF YES, WHERE/WHO WAS ORDERING PHYSICIAN? MONTH/YEAR?

_____

PLEASE ANSWER EACH QUESTION

	YES	NO	COMMENTS
CONSTITUTIONAL:			
Recent weight change	☐	☐	_____
Weakness, fatigue, or chills	☐	☐	_____
Fevers	☐	☐	_____
Loss of appetite	☐	☐	_____
EYES, EARS, NOSE, THROAT:			
Vision changes	☐	☐	_____
Dentures	☐	☐	_____
Problems with hearing	☐	☐	_____
Hoarseness, trouble swallowing	☐	☐	_____
Neck pain/swelling	☐	☐	_____

	YES	NO	COMMENTS
CARDIOVASCULAR:			
Chest pain (palpitations, arrythmias)	☐	☐	_____
Known heart problems	☐	☐	_____
RESPIRATORY:			
Chronic cough	☐	☐	_____
Shortness of breath	☐	☐	_____
Coughing up blood	☐	☐	_____
GASTROINTESTINAL:			
Constipation or diarrhea	☐	☐	_____
Nausea or vomiting	☐	☐	_____
Blood per rectum	☐	☐	_____
Frequent heartburn	☐	☐	_____
MUSCULOSKELETAL:			
Joint pain	☐	☐	_____
Arthritis	☐	☐	_____
SKIN:			
Rashes	☐	☐	_____
Skin cancers	☐	☐	_____
NEURO:			
Headaches	☐	☐	_____
Recent numbness/weakness	☐	☐	_____
History of seizures	☐	☐	_____
PSYCHIATRIC:			
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Hallucinations	☐	☐	_____
Other psychiatric conditions	☐	☐	_____
ENDOCRINE:			
High or low blood sugar	☐	☐	_____
Thyroid problems	☐	☐	_____
HEMATOLOGIC/LYMPHATIC:			
Bleeding tendencies/bruising	☐	☐	_____
BREASTS:			
Pain/discharge/lumps	☐	☐	_____
GENITOURINARY (MALE ONLY):			
Painful urination	☐	☐	_____
Urine frequency	☐	☐	_____
Blood in the urine	☐	☐	_____
Impotence	☐	☐	_____

	YES	NO	COMMENTS
GENITOURINARY (FEMALE ONLY):			
Painful urination	☐	☐	_____
Vaginal discharge	☐	☐	_____
Vaginal bleeding	☐	☐	_____

PLEASE LIST DOCTORS THAT YOU WOULD LIKE TO RECEIVE COPIES OF YOUR REPORTS INCLUDING THE DOCTOR WHO REFERRED YOU.

NAME ADDRESS PHONE #

_____(____)_____-_____

_____(____)_____-_____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

I authorize ANY MEDICAL ENTITY to release my medical records to Orange County Radiation Oncology Center.

Patient Name: _____ Date of Birth: _____/_____/_____

This authorization for release of information covers the period of healthcare:

☐ All past, present, and future periods ***OR*** from: _____ (Date) to: _____ (Date)

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records
☐ Alcohol/drug abuse treatment
☐ Communicable diseases (including HIV and AIDS)
☐ Other (please specify): _____

The purpose of this release:

Medical Records

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effective for 90 days from the date of my signature below.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or personal representative Relationship to the patient

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PERMISSION TO APPEAL DENIED CHARGES FOR SERVICES FORM

Your insurance company requires permission from you to appeal any and all services provided to you which have been billed and denied by your insurance company. Our Billing Company, SightLine Health, will immediately appeal any and all denials for services provided and billed on your behalf to your insurance company, with your permission.

By signing below, you give permission for our billing company to appeal any and all claims denied by your insurance company. This will include all appeal levels, if necessary.

Name of Insurance:_____

Print Your Name: _____ DOB: _____

Sign Your Name: _____ Date: _____

If you are not the patient, what is your relationship to the patient: _____

FORMA DE PERMISO PARA APELAR CARGOS NEGADO POR SERVICIOS

Su compañía de seguros requiere el permiso de usted para apelar cualquier y todos los servicios proporcionados a usted que han sido facturados y negado por su compañía de seguros. Nuestra compañía de facturación, SightLine Salud, inmediatamente apelar todas las denegaciones y cada uno de los servicios prestados y facturados a su nombre para su compañía de seguros, con su permiso.

Al firmar abajo, usted da permiso para que la empresa de facturación Dr. _____ para apelar cualquier y todo reclamo negado por su compañía de seguros. Esto incluirá todos los niveles de apelación, si es necesario.

Nombre de Seguro:_____

Escriba su Nombre: _____ Fecha de nacimiento: _____

Firma: _____ Fecha: _____

Si Usted no es el paciente, Cual es su relacion con el paciente:

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Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to OC Radiation Oncology (the "Provider") for any services furnished to me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

Patient/Guardian Signature: _____ Date: _____

Medi-gap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medi-gap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medi-gap insurer listed below any information needed to determine benefits payable for services from the Provider. This assignment is effective until evoked by me in writing.

Medi-gap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: _____ Date: _____

Receipt of Notice of HIPAA Privacy Practices

I have received the Orange County Radiation Oncology Notice of Privacy Practice from the Provider.

Patient/Guardian Signature: _____ Date: _____

Your Health Information Privacy Rights

Privacy is important to all of us

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

Providers and health insurers who are required to follow this law must comply with your right to...

Ask to see and get a copy of your health records

You can ask to see and get a copy of your medical record and other health information. You may not be able to get all of your information in a few special cases. For example, if your doctor decides something in your file might endanger you or someone else, the doctor may not have to give this information to you.

- In most cases, your copies must be given to you within 30 days, but this can be extended for another 30 days if you are given a reason.
- You may have to pay for the cost of copying and mailing if you request copies and mailing.

Have corrections added to your health information

You can ask to change any wrong information in your file or add information to your file if it is incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file.

- In most cases the file should be changed within 60 days, but the hospital can take an extra 30 days if you are given a reason.

Receive a notice that tells you how your health information is used and shared

You can learn how your health information is used and shared by your provider or health insurer. They must give you a notice that tells you how they may use and share your health information and how you can exercise your rights. In most cases, you should get this notice on your first visit to a provider or in the mail from your health insurer, and you can ask for a copy at any time.

Decide whether to give your permission before your information can be used or shared for certain purposes

In general, your health information cannot be given to your employer, used or shared for things like sales calls or advertising, or used or shared for many other purposes unless you give your permission by signing an authorization form. This authorization form must tell you who will get your information and what your information will be used for.

Your Health Information Privacy Rights

Privacy is important to all of us

Other privacy rights

You may have other health information rights under your state's laws. When these laws affect how your health information can be used or shared, that should be made clear in the notice you receive.

For more information

This is a brief summary of your rights and protections under the federal health information privacy law. You can ask your provider or health insurer questions about how your health information is used or shared and about your rights. You also can learn more, including how to file a complaint with the U.S. Government, at the website at www.hhs.gov/ocr/hipaa/.

Published by:

U.S. Department of Health & Human Services
Office for Civil Rights

Providers and health insurers who are required to follow this law must comply with your right to...

Get a report on when and why your health information was shared

Under the law, your health information may be used and shared for particular reasons, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or making required reports to the police, such as reporting gunshot wounds. In many cases, you can ask for and get a list of who your health information has been shared with for these reasons.

- You can get this report for free once a year.
- In most cases you should get the report within 60 days, but it can take an extra 30 days if you are given a reason.

Ask to be reached somewhere other than home

You can make reasonable requests to be contacted at different places or in a different way. For example, you can have the nurse call you at your office instead of your home, or send mail to you in an envelope instead of on a postcard. If sending information to you at home might put you in danger, your health insurer must talk, call, or write to you where you ask and in the way you ask, if the request is reasonable.

Ask that your information not be shared

You can ask your provider or health insurer not to share your health information with certain people, groups, or companies. For example, if you go to a clinic, you could ask the doctor not to share your medical record with other doctors or nurses in the clinic. However, they do not have to agree to do what you ask.

File complaints

If you believe your information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with your provider or health insurer. The privacy notice you receive from them will tell you who to talk to and how to file a complaint. You can also file a complaint with U.S. Government.