Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

DIABLO VALLEY ONCOLOGY & HEMATOLOGY MEDICAL GROUP, INC.

RADIATION DEPARTMENT

400 TAYLOR BOULEVARD, SUITE 101, PLEASANT HILL, CALIFORNIA 94523

PATIENT INFORMATION

Please Print Clearly & Fill Out Completely

Last Name	First Name	Middle Initial
Date of Birth	Age	Social Security Number
Address		
City	State / Zip	Email
Home Phone	Cell Phone	Work Phone

PHYSICIAN INFORMATION

Physician Who Referred You To Our Office	Diagnosis or Reason for Referral
Primary Care Physician	Physician You Are Seeing At Our Office

PRIMARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the Insurance Card:

Social Security Number	Date of Birth	
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a specialist? ❑ NO ❑ YES (If YES, please give referral slip to receptionist)

SECONDARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the insurance card:

Social Security Number	Date of Birth	
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a specialist? ❑ NO ❑ YES (If YES, please give referral slip to receptionist)

EMERGENCY CONTACT

Name	Relationship	Phone

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Diablo Valley Oncology & Hematology Medical Group, Inc. (DVOHMG) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center to release information requested by DVOHMG. I authorize DVOHMG to release information to physicians referred by DVOHMG. I authorize payments of assigned medical benefits to be paid directly to my physician and DVOHMG. I am responsible for deductibles, coinsurance, and non-covered items. I agree to pay any co-payments required by my insurance plan at the time of service. I understand that Diablo Valley Oncology does not bill tertiary insurances, other than Medicare or MediCal.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

PATIENT DEMOGRAPHICS

RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian

GENDER / STATUS

GENDER: ❑ Male ❑ Female

MARITAL STATUS:

- ❑ Decline to Answer
- ❑ Single
- ❑ Divorced
- ❑ Married
- ❑ Domestic Partner
- ❑ Widow
- ❑ Other

PREFERRED LANGUAGE

- ❑ Decline to Answer
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Punjabi
- ❑ Hindi
- ❑ Sign Language - Deaf
- ❑ Vietnamese
- ❑ Chinese
- ❑ Russian
- ❑ Tagalog
- ❑ Italian
- ❑ Other

CONTACT PREFERENCE

Check <u>One</u>:
❑ HOME ❑ CELL ❑ WORK ❑ MAIL

OCCUPATION

Current or Previous:

PRACTICE SELECTION

What factors helped you choose our practice for your medical care? *(Check all that apply)*

- ❑ Referred by Physician
- ❑ Hospitalist Referral
- ❑ Convenient Location
- ❑ Comprehensive Services
- ❑ Reputation of Practice
- ❑ Reputation of Physicians
- ❑ Family/Friend Recommended
- ❑ Better Business Bureau
- ❑ Website
- ❑ News Story
- ❑ Articles in Papers
- ❑ Newspaper Ad
- ❑ Community Event
- ❑ Social Media
- ❑ Speaker Program
- ❑ Other

May we keep you informed of DVO news & events via confidential Email? ❑ Yes ❑ No Email:

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer	☐	☐	
Heart Disease	☐	☐	
Have you had an EKG?	☐	☐	When/Where?
High Blood Pressure	☐	☐	
Pacemaker	☐	☐	
Reflux or Stomach Ulcers	☐	☐	
Diabetes	☐	☐	
Arthritis	☐	☐	
Stroke	☐	☐	
Lung Disease (Asthma, Emphysema, Pneumonia)	☐	☐	
Prostate Disease	☐	☐	
Bladder Disease	☐	☐	
Seizures	☐	☐	
Mental Illness (Nervous condition/Depression)	☐	☐	
Any other illnesses?	☐	☐	
Have you had any accidents/injuries within the last 24 months?	☐	☐	
Have you ever received the Shingles Vaccine?	☐	☐	
Do you have an Advanced Directive?	☐	☐	

PAST SURGICAL HISTORY

Type of Operation	Date(s)

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

CANCER TREATMENT HISTORY

	YES	NO	Area of Body	Facility / City
Have you ever had radiation or x-ray treatments?	☐	☐		
Have you ever had chemotherapy?	☐	☐		
Did you have any adverse reactions to treatment?	☐	☐	If Yes, describe:	
Have you ever participated in a Clinical Trial?	☐	☐		
Would you like information on Clinical Trials?	☐	☐		
Names of All Physicians & Office Locations/Addresses:				

GYNECOLOGICAL HISTORY (FEMALES)	YES	NO	
Is there any chance you could be pregnant?	☐	☐	
Have you ever taken birth control pills?	☐	☐	
Have you ever taken hormone replacement therapy?	☐	☐	If yes, when:
Do you have a family history of breast cancer?	☐	☐	

Number of pregnancies	Number of live births	Age at first pregnancy
Did you breastfeed?	Date of last mammogram	Date of last pap smear
Onset of menstruation (age)	Age at menopause	

FAMILY HISTORY

RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			

Are you of Ashkenazi Jewish descent?	YES	NO	

REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO		YES	NO
Weight loss	☐	☐	Chest Pain/Palpitations	☐	☐
Fevers	☐	☐	Mood changes or Depression	☐	☐
Chills	☐	☐	Trouble sleeping	☐	☐
Skin rash or itching	☐	☐	Frequent indigestion	☐	☐
Headaches	☐	☐	Nausea or vomiting	☐	☐
Loss of balance or coordination	☐	☐	Diarrhea or constipation	☐	☐
Hearing loss	☐	☐	Jaundice	☐	☐
Vision trouble	☐	☐	Rectal bleeding	☐	☐
Do you wear contacts or glasses?	☐	☐	Foul-smelling urine	☐	☐
Arm or leg weakness	☐	☐	Blood in urine	☐	☐
Arm or leg numbness	☐	☐	**FOR MEN:**		
Sinus drainage	☐	☐	Decrease in size or force of urine stream	☐	☐
Difficulty swallowing	☐	☐	Difficulty with sex or impotence	☐	☐
Hoarseness or change in voice	☑	☐	**FOR WOMEN:**		
Sores in mouth or lip	☐	☐	Lump, discharge or breast pain	☐	☐
Cough	☐	☐	Irregular menstrual bleeding	☐	☐
Coughed up or spit up blood	☐	☐	Irregular vaginal bleeding or discharge	☐	☐

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
☑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always
☐	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
☐	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
☐	STREET DRUGS/OTHER	Year: Type:

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

PAIN

Location of pain: ❒ No Pain

Describe the pain (**Circle all that apply**): sharp dull burning aching throbbing tender numb stabbing gnawing shooting exhausting penetrating miserable unbearable continuous occasional

What makes it better? _____

What makes it worse? _____

Does medication help? ❒ Yes ❒ No
Name of medication(s):_____

How bad is your pain today?
Please check the appropriate box.

Wong-Baker Faces of Pain Rating Scale

☐ ☐ ☐ ☐ ☐ ☐

ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Other (List All):

Describe Reaction(s):

CURRENT MEDICATION LIST

D/C DATE	DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. E-prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Diablo Valley Oncology to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Diablo Valley Oncology (DVO) has an Onsite Physician Dispensing Pharmacy for your convenience. We use the same software and have the same relationship with insurance companies & Medicare as any retail pharmacy. Prescriptions filled on site at DVO take just a few minutes. Our service is particularly helpful for new prescriptions and refills given to you while you're here in the office. In addition to our most frequently prescribed medications, we focus on stocking medications that have been difficult for our patients to acquire. The co-pay costs are no different than they would be in your local pharmacy and are sometimes better. Our staff will do everything possible to help lower your co-pay and will also provide support and information on medication assistance programs. *There is no obligation to have prescriptions filled at DVO. You may continue to receive your medications at the pharmacy of your choice.*

Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy:

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

PATIENT INFORMATION AUTHORIZATION – HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

CONTACT PREFERENCE *(Check ONE):* ❑ HOME ❑ CELL ❑ WORK ❑ MAIL

Below…Please check ALL that apply:

HOME PHONE	CELL PHONE	WORK PHONE	MAIL / FAX
❑ OK to leave detailed message*****	❑ OK to leave detailed message*****	❑ OK to leave detailed message*****	❑ OK to send mail to my Home
❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ OK to send mail to my Work
HOME # (with Area Code)	**CELL #** (with Area Code)	**WORK #** (with Area Code)	OK to **FAX** to my Work at:

***** *Either with any individual, other than yourself, whom answers the phone or on an answering machine.*

OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

NAME *(List all that apply)*	**RELATIONSHIP TO YOU**	**CONTACT INFO**
	Spouse / Significant Other	Phone:
		Phone:
		Phone:
		Phone:

I request the following restrictions to the use or disclosure of my health information:

My signature below authorizes Diablo Valley Oncology & Hematology Medical Group, Inc. (DVO) to use my Protected Health Information per my instructions above and acknowledges that I have received DVO's Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
DVO Witness Name / Signature	Date

TREATMENT COUNSELING & NUTRITION CONSULTATION

You will meet with the Nurse Practitioner or Physician Assistant to discuss the treatment regimen your physician has recommended for you. You may wish to come to this appointment with a prepared list of questions, and we encourage you to bring a family member, caregiver or friend with you. We will make every attempt to answer all your questions. This is typically a 30 minute appointment.

We will explain:
- Your specific treatment regimen
- Each of the medications you will be given, the potential side effects and how to manage them
- When your treatments will begin and how long the course of treatment will take

You will be provided with:
- A consent form for treatment
- Educational materials

You will be scheduled for a second Counseling session to include:
- An orientation to our practice
- Information on community resources
- Nutrition Consultation with a Registered Dietician

INSURANCE BENEFITS REVIEW

In advance of your treatment counseling, one of our Reimbursement Coordinators will research and review your insurance benefits as they apply to the specific treatment regimen you are to receive. As a convenience to you, we will meet with you in person immediately following your treatment counseling to share what we learn. This will assist you in coordinating payments for our services. This meeting, which usually takes 10 minutes, may be done in person or by phone but must be done before your treatment can begin.

During the meeting we will explain:
- The cost of your specific treatment regimen
- Your specific insurance benefits (including co-pays, co-insurance, deductible & out-of-pocket maximum)
- Your personal financial responsibility

You will be provided with:
- A summary of your insurance benefits
- Your out-of-pocket costs for your specific treatment regimen
- Information on Patient Assistance resources (if needed)

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First *Middle Initial* *Last*

CO-PAYMENT, DEDUCTIBLE & CO-INSURANCE COLLECTION POLICY

We are required by law, and your health plan, to collect co-payments at the time of service. Co-payments are required each time you are seen by the physician or nurse practitioner, and each time you receive medication in our Infusion Center, even if the physician or nurse practitioner does not see you. This co-payment is for the limited office visit charge that covers the medical management that the physician provides in overseeing your treatment. **This policy is established by your health plan** and is explained in your benefits handbook and is usually printed on your insurance card.

For patients going on treatment plans, we inform you in the Insurance Benefit Review what your personal financial responsibility is for the specific treatment regimen you will be on. We do collect for your deductible and co-insurance as applicable at the beginning of each treatment cycle. If you have questions or concerns about your insurance coverage, please call your insurance carrier directly.

INSURANCE REIMBURSEMENT & BILLING POLICIES

BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you. Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as many of our patients prefer, we will bill your primary and secondary insurance carrier for you. Diablo Valley Oncology does not bill tertiary insurance coverage other than Medicare or MediCal. For us to do so, you must sign the "*Release of Information & Assignment of Benefits*" statement on the first page of this packet or on the "*Change of Insurance*" form. We will bill your insurance a maximum of three (3) times, then the responsibility for handling issues with insurance reimbursement rests with you. You are ultimately responsible for payment of your bill.

When you receive our monthly statement, payment is expected within thirty (30) days. Payments are considered delinquent after sixty (60) days. If statements are not paid after this sixty-day (60) period, a late charge will be assessed on the unpaid balance at a rate of 1% per month, compounded monthly, unless alternative payment arrangements are made in writing. If Diablo Valley Oncology or its physicians are not contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service.

ATTORNEY FEES AND COLLECTION COSTS: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.

SUSPENSION OF CARE (EXCEPT EMERGENCY CARE): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues directly with our billing department.

ADMINISTRATIVE FEES

Due to the high volume of requests we receive, we charge administrative fees for copying of all or part of a medical record, completion of disability forms, printouts of your billing statements, and other such administrative requests. The current fee schedule (which is subject to change) is:

Printing of Medical Records Fee:	$15.00 + .25 cents per page
Disability Forms:	$15.00
All Other Administrative Requests:	$15.00
Returned Check Charge:	$20.00

My signature below indicates that I have read, understood and agreed to the Co-Payment and Insurance Reimbursement & Billing Policies of Diablo Valley Oncology & Hematology Medical Group, Inc.

Signature: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
Signature: Physician	Date
Print Name: Physician	

A copy of this page will be provided to you at your request.

Revised: 7/18/12