GAMMA WEST CANCER SERVICES
Taking Cancer Personally

PATIENT REGISTRATION

Contact Information

Name _____

Address _____
Street City State Zip

Date of Birth _____ Age_____

Home Phone _____ Cell Phone _____

Email Address_____

Referring Physician _____ Phone _____

Primary Care Physician_____ Phone _____

Emergency Contact_____ Relation_____ Phone _____

Attention: We will use the address above and all phone numbers and addresses listed to contact you, mail copy of office visit notes and/or leave messages, and speak to friends or family involved in your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.

Personal Information

Male ____ Female ____ Marital Status (circle one) S M D W

Ethnic Origin: Caucasian ___ African American ___ Hispanic ___ Asian ___ Native American ___

Ethnicity: Hispanic/Latino ___ Not Hispanic/Latino___ Decline to Answer_____

Spoken Language_____ Preferred Language_____

Insurance Information

Have you been, or are you currently in a nursing facility? ☐ Yes ☐ No

Are you on Hospice? ☐ Yes ☐ No

If yes, what were the dates? _____

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Primary Insurance

Name of Insurance_____

Subscriber _____ DOB _____

Member ID _____ Group# _____ Effective Date_____

Guarantor Name _____ Relation to Patient _____
(Person responsible for payment if other than patient)

Address _____ Phone Number _____

Secondary Insurance

Insurance _____

Subscriber _____ DOB _____

Member ID _____ Group# _____ Effective Date_____

Guarantor Name _____ Relation to Patient _____
(Person responsible for payment if other than patient)

Address _____ Phone Number _____

I agree that all of the information above is accurate and current. My signature indicates that I fully understand and agree to the above terms. I further grant authorization for all evaluations and diagnostic procedures performed.

_____

Patient Signature Date

_____

Guarantor's Signature (if other than patient) Date

CONSENT TO PHOTOGRAPH

"I consent to be photographed for the purpose of patient identity in my medical records and imaging for treatment purposes. I understand that the photographs or images will not be published for any purpose without my prior written consent."

_____

Patient Signature Date

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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 & All Medical Entities (healthcare providers) to release my medical records to the following individual or entity:

Name of Entity: GammaWest Cancer Services

Address: _____
Street City State Zip

Patient Name: _____ DOB: _____ SS# _____
Optional

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

☐ All Past, Present, and Future Periods ***OR*** ☐ From: _____ To: _____
Date 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 ☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment ☐ Other (please specify): _____

The purpose of this release: _____

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 or not 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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MEDICARE LIFETIME ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to GammaWest Cancer Services (the "Provider") for any services furnished 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: _____

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NOTICE OF HIPPA PRIVACY PRACTICES

I acknowledge that I have been offered/given a copy of the GammaWest Cancer Services Notice of Privacy Practices. I understand that if I have questions or concerns, I may contact the Facility Privacy Official.

_____ _____

Patient Signature Date

****

DISCLOSURE OF FINANCIAL INTEREST

Because of concerns there may be conflict of interest when a physician refers a patient to a healthcare facility for other treatment in which the physician has a financial interest, the State of Utah passed a law. The law requires that I disclose this financial interest to you and provide and state that you may choose any facility or service center for the purpose of having this treatment performed. This disclosure is intended to help you make a fully informed decision about your health.

For more information about alternative providers, please ask me or my staff.

The physicians at GammaWest Cancer Services or their family member(s) have a financial interest in GammaWest which provides brachytherapy service.

ACKNOWLEDGMENT

I have read and understand the above notice.

_____ _____

Patient Signature Date

E-MAIL CONSENT FORM

_____

Patient's name (printed)

_____

Patient's home address

_____ _____

Patient's e-mail address | Patient's home phone number

_____ _____

Patient's cell phone number | Cell phone provider

DO NOT USE EMAIL FOR EMERGENCY, URGENT & SENSITIVE PROBLEMS!

E-mail should never be used for emergency or urgent problems. **For a life-threatening emergency, call 911**. **For urgent or sensitive problems, call the office at 801- 456- 8401**. We recommend office visits for all new, complex or sensitive problems. When we are not in the office, the answering message will direct you to an on-call doctor who can give advice or direct you to a source of emergency or urgent care.

1. RISKS OF USING E-MAILTO COMMUNICATE WITH YOUR PROVIDER

The term "Provider" in this consent refers to GammaWest Cancer Services and the staff. The Providers offer patients the opportunity to communicate by e-mail. However, transmitting patient information by e-mail has risks that patients should consider. Risks include, but are not limited to:

- E-mail can be circulated, forwarded, and stored in paper and electronic files.
- E-mail can be broadcast worldwide or can be received by unintended recipients at home or at work.
- E-mail senders can accidentally type the wrong email address or send to others besides the intended recipient.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be used as evidence in court.
- E-mail can introduce viruses or worms into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must give signed consent to the use of patient information in e-mail, indicating agreement with these conditions:

- All e-mails to or from the patient concerning treatment will be added to the patient's medical record. Therefore, other individuals authorized to access the medical record will have access to those e-mails.
- Provider may forward e-mails internally to Provider's staff as necessary for treatment, payment, and operations. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Provider or staff shall confirm when an e-mail from the patient has been received and read. However, the patient shall not use e-mail for medical emergencies, urgent problems or other time sensitive matters.
- If the patient's e-mail requires or requests a response from Provider, and the patient has not received a response within 3 days, the patient is responsible to follow up to determine whether the intended recipient received the e-mail and when he/she will respond.
- The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- The patient is responsible for informing Provider of any other types of information the patient does not want to be sent by e-mail.
- The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

- Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines or treating patients who have not first been seen in the office.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer's computer.
- Inform Provider of changes in his/her email address.
- Confirm that he/she has received and read an e-mail from the Provider.
- Put the patient's name in the body of the e-mail.
- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
- Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to Provider.
- E-mail should be brief, and to the point.

4. ALTERNATE FORMS OF COMMUNICATION

I understand that I may also communicate with the Provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. If no response from email is received after 3 days, the patient should call the office.

5. TYPES OF E-MAIL TRANSMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE

Types of information that can be communicated via e-mail with the Provider include prescription refills, referral requests, appointment scheduling requests, billing and insurance questions, patient education, and clinical consultation. If you are not sure if the issue you wish to discuss should be included in an e-mail, please call Provider's office to schedule an appointment.

6. HOLD HARMLESS

I agree to indemnify and hold harmless the Provider, GammaWest Cancer Services, its employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or to use Provider's Web Site **gammawest.com**, any arrangements made based on information obtained at the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the Provider's Site or the server that makes the Site available is free of viruses or other harmful components.

7. TERMINATION OF THE E-MAIL RELATIONSHIP

Provider has the right to immediately terminate the e-mail relationship with a patient if he/she determines, in his/her sole discretion, that patient has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the Provider determines, in his/her sole discretion, to be unacceptable. The e-mail relationship between the Provider and the patient will terminate in the event the Provider, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of his/her patients. Patient also has the right to terminate the email relationship by written notice to Provider, at any time.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form and discussed it with the Provider or his/her representative. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I had were answered.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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GENERAL HEALTH HISTORY

Patient Name:				Date of birth:	
Age:	Sex:	Married:	Height:	Weight:	Race:
Current Cancer Diagnosis:					

General			
	YES	**NO**	**COMMENTS**
Have you ever been diagnosed with cancer before? If yes, what type of cancer and were you treated with radiation or chemotherapy?			
Do you have or have you had any illness of which your doctor should be aware?			
Have you had a flu shot?			
Have you ever had a serious injury?			
List all surgeries that you have had: _____ _____ _____ _____ _____ _____ _____ _____			
Are you taking any hormone medications or receiving any hormone injections? If yes, please specify (i.e. Lupron, Bicalutamide, Firmagon, Estrogen)			
Family History			
Do you have a family history of cancer? If yes, please explain. Parent:_____ Parent:_____ Sibling:_____ Sibling:_____ Other:_____			
Tobacco/Drug/Alcohol History			
Do you now or have you ever abused drugs?			
Are you currently using tobacco?			

	YES	NO	COMMENTS
Have you ever been a user of tobacco?			
How many pack/day and for how many years?			
Tell us about the amount of alcohol you currently use or have used in the past:			
Weight Change			
Have you had any weight change in the past 3 months?			
Fatigue			
Do you have fatigue? How would you describe your energy level? (Decreased, Normal, Increased)			
Vision			
Do you have any problems with your eyes or vision? If yes, please explain.			
Do you wear glasses or contacts?			
Ears			
Do you have any problems with your ears or hearing? If yes, please explain.			
Do you wear hearing aids?			
Do you have ringing in your ears?			
Nose			
Do you have any problems with your nose? If yes, please explain.			
Throat			
Do you have any problems with your throat? If yes, please explain. (i.e. hoarseness)			
Do you have difficulty swallowing?			
Cardiovascular			
Does your doctor need to know anything about your heart? (i.e. arrhythmia, high blood pressure, etc.) If yes, please explain.			
Have you ever had a heart attack?			
Have you ever had a stroke?			
Do you have a pacemaker?			
Respiratory			
Do you have any respiratory problems or illnesses the doctor should know about? (i.e. asthma, shortness of breath) If yes, please explain.			
Do you use oxygen at home? If yes, how many liters?			
Gastrointestinal			
Do you have any problems with your stomach or bowels? If yes, please explain.			
Have you had a colonoscopy? Was it normal and was it done in the last 9 years?			

	YES	NO	COMMENTS
GYN Genitourinary (Females Only)			
Have you taken any hormones in the past?			
Age of first menstrual period			
Menopause history, at what age?			
Tell us about your pregnancy history, number of pregnancies and number of live births.			
Have you recently had a pap smear? Date of last pap smear			
Any pelvic problems (i.e. pain, infections, organ prolapse)			
Have you recently had a mammogram? Date of last mammogram			
Have you noticed any problems with your breasts? If yes, please explain.			
Skin			
Do you have any problems with your skin or had excessive sun exposure?			
Musculoskeletal			
Are you having any problems with your bones, joints, or muscles? If yes, please explain.			
Do you have arthritis? Location of arthritis			
Neurological			
Do you have any neurological problems the doctor needs to know about? If yes, please explain.			
Do you have headaches? If yes, how often?			
Have you noticed numbness or tingling in your fingers or toes?			
Do you have seizures?			
Do you have problems with dizziness?			
Have you fallen recently?			
Psychological			
Do you feel depressed or are you being treated for depression?			
Thyroid			
Do you have a history of thyroid disease?			
Diabetes			
Are you a diabetic? How do you control your diabetes?			
Advanced Directives			
Do you have a Healthcare Proxy?			
Do you have a Living Will?			

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MEDICATION LIST

Name of Medication/Vitamin	Dose	Frequency

Allergies:_____

Preferred Pharmacy:_____
Phone number (if known)

Patient Name:_____ DOB_____

Falls Risk: A Self-Assessment

To find out if you are at risk for falls, answer the questions below

	Yes	No
Have you fallen two or more times in the past year?		
Have you Fallen with injury in the past year?		
Do you experience dizziness and/or have trouble keeping your balance?		
Is walking difficult due to muscle weakness, stiff joints, or foot problems?		
Are you on more than three medications?		
Do you have problems with your vision that is not corrected with glasses?		
Do you make frequent or hurried trips to the bathroom?		
Are there fall hazards in your home? I.e.: uneven steps, rugs, poor lighting, slippery floors		
Does the fear of falling reduce your physical or social activity?		
Do you ever feel lonely, depressed, isolated or unable to concentrate?		
Do you consume alcohol more than occasionally?		
Do you use (or have been encouraged to use) a cane or walker?		
Are you over the age of 75?		
Total:		

Add the total of the Yes column to determine your risk of falling.

0-5 points = Low Risk 6-8 points = moderate risk 8+ points = High Risk

Patient Name_____ Date_____