Imperial Valley Radiation Oncology

Affiliated with UC San Diego Health PHYSICIAN NETWORK™

WELCOME TO Impreial Valley Radiation Oncology

LOCATIONS:

EL CENTRO, CA
1410 S La Brucherie Rd,
Suite N
El Centro, CA 92243
Ph: (760) 339-5620

Impreial Valley Radiation Oncology is an affiliate practice of UCSD and offers radiation oncology to patients around the El Centro area.

At Impreial Valley Radiation Oncology, our mission is to combine world-class cancer care with a deep and heart-felt commitment to the wellbeing of our patients and families. We are here to take care of you every step of the way during this difficult time. Our highly specialized radiation oncologists will determine the treatment plan to help achieve the best possible outcome. We will keep you and your caregivers informed and supported from diagnosis through treatment. For your first visit, please fully complete and sign all forms included in your packet. You will need to present these forms to the front desk upon your arrival. If you are unable to complete these forms before your first appointment, please arrive 30 minutes early and we will assist you. **If you need to reschedule or cancel your appointment, please call at least 24 hours before your scheduled visit.**

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available. We accept most insurance carriers and our staff will work with you to ensure that you have the coverage you will need.

WE ASK THAT PATIENTS ALWAYS:

- Bring insurance cards to each visit. **If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure that we have all information. Please make sure to bring all your cards.**
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over the-counter medications currently taken. Please bring your prescription card. Some patients find it more convenient to bring the medication bottles to the appointment. Note that over the counter drugs include vitamins, herbs, aspirin, Tylenol, etc. Some patients find it more convenient to bring the medication bottles to the appointment.
- Allow a 72-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- **Consider the compromised immune systems of other patients, and refrain from bringing children to your appointments. If you are feeling ill, please call us prior to your appointment so we can provide guidance.**
- Write down any questions or concerns that arise to discuss with the physician. Once a patient has made an appointment, all facets of our services-from the latest research findings to the most advanced technology-will be utilized in providing the highest level of quality medical care.

Again, we welcome you and say thank you for choosing Impreial Valley Radiation Oncology. For further information, please visit our website at **www.ivro-sbro.com**. Should you need additional assistance, please call, (760) 339-5620.

MRN:

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PATIENT REGISTRATION

PLEASE PRINT CLEARLY Today's Date: _____

Patient Name: _____

DOB: ____ /____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ May we email you? ☐ Yes ☐ No

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American

☐ Asian/Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ Work Phone: (_____) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Are you currently receiving home health? ☐ Yes ☐ No

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Patient Initials: _____

MRN:

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PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: (___) _____

Have you completed Advanced Directives? ☐ Yes ☐ No
(check all that apply) ☐ Living Will ☐ DNR ☐ Durable Power of Attorney

Durable Power of Attorney Relation to you: _____

If none, do you wish to learn about Advance Directives? ☐ Yes ☐ No *Please provide a copy for our records

Primary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage: _____

Secondary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials: _____

Witness Name: _____ Witness Relationship: _____

Witness Signature: _____

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MEDICAL HISTORY FORM

REVIEW OF SYSTEMS:

(Please check any past or current symptoms you have.)

Allergic/ Immunologic:
- ☐ Allergies
- ☐ Reaction

Cardiovascular:
- ☐ Arrhythmias
- ☐ Edema
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Shortness of Breath

Constitutional:
- ☐ Appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Lethargy
- ☐ Malise
- ☐ Rigors / Chills
- ☐ Weight Change

Endocrine:
- ☐ Diabetes – Type 1 / Type 2
- ☐ Thyroid Disorder
- ☐ Hot Flashes

Head and Neck:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dysphagia
- ☐ Ear pain
- ☐ Glaucoma
- ☐ Hard of hearing
- ☐ Hoarseness
- ☐ Mouth Dryness
- ☐ Neck Masses
- ☐ Otitis
- ☐ Sputum production
- ☐ Tinnitus
- ☐ Visual acuity

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Blood or Black Stools
- ☐ Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn/dyspepsia
- ☐ Hemorrhoids
- ☐ Melanea/GI bleeding
- ☐ Nausea
- ☐ Pain/Cramping
- ☐ Satiety
- ☐ Vomiting
- ☐ Vomiting up Blood

Genitourinary:
- ☐ Dysuria
- ☐ Frequency
- ☐ Genital Masses
- ☐ Hematuria
- ☐ Incontinence
- ☐ Nocturia
- ☐ Sexual Function
- ☐ Urgency
- ☐ Urine Color Change
- ☐ Vaginal discharge/bleeding
- ☐ Vaginal Spotting

Hematologic/lymphatic:
- ☐ Anemia/bleeding/bruising
- ☐ Lymphedema

Integumentary (Skin):
- ☐ Blisters
- ☐ Bruising
- ☐ Dry Skin/Itching
- ☐ History of Skin Cancer
- ☐ Lesions/Moles
- ☐ Nails
- ☐ Photosensitivity
- ☐ Pruitius
- ☐ Rash
- ☐ Urticaria

Musculoskeletal:
- ☐ Arthritis
- ☐ Bone / Muscle Pain
- ☐ History of Fractures
- ☐ Joint Pain/Joint Swelling
- ☐ Limited Range of Motion

Neurologic:
- ☐ Disorientation
- ☐ Balance/Dizziness
- ☐ Gait
- ☐ Insomnia
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Word searching
- ☐ Headache/migraine
- ☐ Focal weakness
- ☐ Neuropathy
- ☐ Speech Impairment
- ☐ Tremor
- ☐ Altered Consciousness

Psychiatric:
- ☐ Anxiety
- ☐ Delusions
- ☐ Depression
- ☐ History of mental illness
- ☐ Mood-euphoria

Respiratory:
- ☐ Cough
- ☐ Coughing up blood
- ☐ Hiccups
- ☐ Uses oxgen
- ☐ Wheezing

Signature: _____ Date: _____

Patient Initials: _____

MRN:

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MEDICAL HISTORY FORM

OTHER ILLNESS OR MEDICAL PROBLEMS:

(Please list current and past medical problems that you have been treated for AND the physician who treated you.)

Illness / Medical Problem

_____

_____

_____

_____

_____

_____

MEDICATION LIST:

Mail order Name: _____ Phone: (_____) _____ ID #: _____

Pharmacy Name: _____ City: _____ Phone: (_____) _____

Please list all medications: Prescription / over the counter / vitamins / supplements
List dosage and how often you take (example: Flomax 0.4mg, 1 tablet a day)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Initials: _____

ALLERGIES AND SENSITIVITES:

(List Allergies you have and how each affects you.)

☐ No known allergies ☐ No known drug allergies ☐ Latex

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a reaction to anesthetic? ☐ Yes ☐ No

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MEDICAL HISTORY FORM

SURGICAL HISTORY:

☐ No Past Surgery

Procedure	Date Performed	By Whom

Do you have an implanted device, such as a pacemaker? ☐ Yes ☐ No
If yes, please provide a copy of your device card for our records

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Have you had radiation or chemotherapy treatment in the past? ☐ Yes ☐ No

GYNECOLOGIC:

Heavy Periods: ☐ Yes ☐ No

Age Period Started: _____ Date of Last Period: _____

# of Pregnancies: _____ Abortions / Miscarriages? ☐ Yes ☐ No

Children: ☐ Yes ☐ No If yes, how many? _____

Breastfeed: ☐ Yes ☐ No

Date of last pap: _____ Date of last Mammorgram: _____

Date of most recent: _____

FAMILY MEDICAL HISTORY:

Indicate any family members with breast, ovarian, pancreatic, prostate, melanoma, colon, kidney or uterine cancer, blood disease or other disease.

	Age:	Disease:	If deceased, cause of death:
Father:			
Mother:			
Maternal Grandparents:			
Paternal Grandparents:			

PAIN SCALE:

Are you in pain? ☐ Yes ☐ No

If yes, please indicate on a scale of 1-10 (0= no pain, 10= worst pain)

1 2 3 4 5 6 7 8 9 10

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SOCIAL HISTORY

SOCIAL HISTORY:

Work Hazards:

Any occupational hazards (like noise or chemical exposures) ☐ Yes ☐ No If yes, what: _____

Tobacco Use: (Present and/or past)

☐ Never smoked

☐ Quit smoking When? _____ How many years did you smoke?____yr(s) Age started: _____
How many packs? _____/day

☐ Currently smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes
How many packs? _____/day How many years? _____

☐ Chewing tobacco ☐ Current ☐ Past How long? _____

Alcohol Use: (Present and/or past)

☐ Non drinker

☐ Beer number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Wine number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Liquor number of bottles _____ per ☐ Day ☐ Week ☐ Month

Living situation:

☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home ☐ Winter Resident ☐ Year Round Resident

Nutritional History:

Has there been a change in your appetite in the past 6 months? ☐ Yes ☐ No

How is your appetite? ☐ Appetite Good ☐ Appetite Fair ☐ Appetite Poor

Have you gained or lost weight in 1 month without wanting to? ☐ Yes ☐ No

If yes, how much gain or loss? _____

Are you happy with your weight? ☐ Yes ☐ No

If not, are you on a diet and exercise program? ☐ Yes ☐ No

Are you taking any extra calcium? ☐ Yes ☐ No

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HEALTH INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO Impreial Valley Radiation Oncology AND ITS ASSOCIATES

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Patient Name: _____ SSN: _____
please print

Telephone Number: _____ DOB: _____

INFORMATION TO BE RELASED FROM/TO: ☐ FROM ☐ TO

I hereby authorize the release of information in my medical record from/to (Provider Name):

_____

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Fax

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/pr test results. Exclusions to the above: _____

_____

INFORMATION TO BE RELASED FROM/TO: ☐ FROM ☐ TO

☐ **EL CENTRO, CA**
1410 S La Brucherie Rd. Suite B
El Centro, CA 92243
Ph: (760) 339-5620

TYPE OF RECORD:

- ☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Psychotherapy notes only
- ☐ Radiology reports (Specify): _____
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report
- ☐ Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)

☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

CONTINUED ON BACK

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE: _____ Date: _____

(Patient / Legal Representative / Guardian)

(PHYSICIAN PART ONLY) Records obtained in the course of PHYSCHIATRIC TREATMENT

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (Note: No approval is required for release to the patient's attorney.)
If denied, please provide reason: _____

Signature: _____ Date: _____

(Physician / Psychologist / Social Worker)

MRN:

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AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

Thank you for choosing Impreial Valley Radiation Oncology as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to Impreial Valley Radiation Oncology to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to Impreial Valley Radiation Oncology.

USE OF PHOTOGRAPHY

I agree the any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-PRESCRIPTION FOR MEDICATION HISTORY

We may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize Impreial Valley Radiation Oncology to release medical and other information to the necessary insurance companies and third party payers requires for payment or rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to Impreial Valley Radiation Oncology. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits form.

Signature of Patient of Guardian: _____ Date: _____

MRN:

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AUTHORIZATION TO RELEASE HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ No, please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ Yes, allow communication with:

Name	Relationship	Phone

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care ☐ Billing and Payment Information

I _____ , understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practice for Impreial Valley Radiation Oncology.

Patient Signature	Print Name	Date

Date of Birth: _____

All Impreial Valley Radiation Oncology providers (physician, nurse practitioner or physician assistant) participate in electronic prescribing directly to your local and mail order pharmacies. Our goal is to assist patients with prescription requests in an efficient and timely manner. In order to process your request as quickly as possible, please see the details of our prescription policy.

- Prescription refills require close monitoring by your physician, nurse practitioner, or physician assistant to ensure the safe continuation of the appropriate dose, frequency and term of that medication. Your provider will prescribe the appropriate number of prescription refills to last you until your next scheduled appointment.
- It is the patient's responsibility to schedule your next appointment in advance and with adequate time to receive a prescription refill.
- Maintaining current pharmacy information is the responsibility of the patient. Please confirm with our practice that your correct local pharmacy address and phone number or mail order pharmacy information is on file. Prescription refill requests will be submitted electronically to your pharmacy. Your pharmacy will contact you when your prescription is ready.
- Prescriptions classified as controlled substances are not processed after hours or on the weekends.
- Please allow 48–72 hours to process prescription requests. Medications requiring pre-authorization may require additional time to process. Please plan ahead for refills during holidays and when traveling.
- Should you require an emergency refill, prescriptions refill requests should be electronically submitted from the pharmacy directly to the office. If approved by your provider, an appropriate refill will be submitted to your preferred pharmacy. If your prescription refill is not approved, please contact your provider's office to schedule an appointment.

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COMMUNICATION AUTHORIZATION TO RELEASE HEALTH INFORMATION

ELECTRONIC COMMUNICATIONS

For your convenience out office communicates through different electronic means including our secure patient portal, phone, and text messaging for appointment reminders.

May We Contact you at:

Home? ☐ Yes ☐ No Number _____ Work? ☐ Yes ☐ No Number _____

Cell? ☐ Yes ☐ No Number _____

Via Email? ☐ Yes ☐ No Email Address _____

May we send appointment reminder via text? ☐ Yes ☐ No

May we leave a message on your answering machine or cell? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

May we leave a message with a family member or other person at your home? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

Please check below if you do NOT want to be contacted by Impreial Valley Radiation Oncology in any of the following methods of communication:

☐ Cell Phone ☐ Text Message ☐ Home Phone ☐ Secure Email ☐ Online Patient Portal

Is it okay to leave a detailed message on your voicemail? ☐ Yes ☐ No

_____ _____

Signature of Patient of Representative Date

MRN:

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PATIENT PAYMENT POLICY

Dear Patient,

Thank you for choosing Impreial Valley Radiation Oncology as your health care provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
    a. Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware the some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Payment.** For your convenience, Impreial Valley Radiation Oncology accepts Checks and Credit Cards. We accept Visa, Mastercard, Discover and American Express
9. **Financial Counselor.** We have a Financial Counselor available as a resource to our patients..
10. **California Open Payments Notice.** The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient of Responsible Party	Date
Print Name	Relationship to Patient