JOSEPH E. COAD RADIATION TREATMENT CENTER

PT NAME: _____ **CHART #:** _____ **DOB:** _____

I acknowledge that I have received the ***MedStar Health*** Notice of Privacy Practices	**FOR *MEDSTAR* STAFF USE ONLY** ☐ **Acknowledgment obtained** ☐ **Acknowledgment not obtained because:** ☐ **Emergency Patient** ☐ **Patient declined to sign** ☐ **Patient unable to sign** **Other** _____

TO WHOM IT MAY CONCERN:

I hereby authorize the Joseph E. Coad Radiation Treatment Center, to release any information regarding my medical history, treatment, and/or billing information to the following:

_____ (Relationship) _____

_____ (Relationship) _____

_____ (Relationship) _____

_____ Relationship) _____

***I understand that I have the right to inspect and receive a copy of the information to be disclosed, and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.**

In an effort to provide the highest quality of service, we now offer automated courtesy calls through TeleVox to remind you of upcoming appointments. Only minimal Protected Health Information (PHI) will be provided to Televox in order to confirm your appointment.

***I consent to receive courtesy call notification of my upcoming appointments through Televox on the cell phone number that I have provided. _____. N/A ☐**
Initials

Do you have **ADVANCE DIRECTIVES? YES ☐ NO ☐**

If **NO,** would you like information regarding **ADVANCE DIRECTIVES? YES ☐ NO ☐**

_____ _____ _____
Patient / Responsible Party Signature **Date** **Time**

ANY SUSPECTED BREACH OF SECURITY, INTRUSION, OR UNAUTHORIZED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) WILL BE REPORTED TO MEDSTAR IN WRITING.

PATIENT REGISTRATION FORM

PATIENT NAME: **DATE:**

ADDRESS:

CITY: **ST:** **ZIP:** **COUNTY:**

PHONE#: **CELL#:** **EMAIL:**

SS#: **DOB:** **AGE:** **BIRTHPLACE (STATE):** **SEX: M / F**

PREFERRED LANGUAGE: **SMOKING HISTORY:** **Current** ☐ **Former** ☐ **Never** ☐

MARITAL STATUS: **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Partnered** ☐

RACE: **WHITE / CAUCASIAN** ☐ **BLACK / AFRICAN AMERICAN** ☐ **ALASKA NATIVE** ☐
AMERICAN INDIAN ☐ **ASIAN** ☐ **NATIVE HAWAIIAN** ☐ **PACIFIC ISLANDER** ☐
OTHER (PLEASE SPECIFY): **PT DECLINED** ☐

ETHNICITY: **NON-HISPANIC / NON-LATINO** ☐ **HISPANIC / LATINO** ☐ **PLEASE SPECIFY:**
OTHER (PLEASE SPECIFY): **PT DECLINED** ☐

EMPLOYER INFORMATION

EMPLOYER: PHONE #: RETIRED: ☐

ADDRESS: CITY: ST: ZIP:

INSURANCE INFORMATION

PRIMARY INSURANCE: POLICY #: GROUP #:

SUBSCRIBER: BIRTH DATE:

SUPPLEMENTAL INS POLICY # GROUP #:

SUBSCRIBER: BIRTH DATE:

RELATIVE / CONTACT PERSON

RELATIVE / SPOUSE'S NAME: RELATIONSHIP:

ADDRESS: CITY: ST: ZIP:

HOME PHONE #: WORK #: CELL PHONE #:

SPOUSE / RELATIVE EMPLOYER:

EMPLOYER ADDRESS: CITY: ST: ZIP:

PHYSICIAN INFORMATION

REFERRING PHYS: PHONE #: FAX #:

ADDRESS: CITY: ST: ZIP:

PRIMARY CARE PHYS: PHONE #: FAX #:

ADDRESS: CITY: ST: ZIP:

OTHER PHYS: PHONE #: FAX #:

ADDRESS: CITY: ST: ZIP:

OTHER PHYS: PHONE #: FAX #:

ADDRESS: CITY: ST: ZIP:

PHARMACY INFORMATION / E-PRESCRIBE CONSENT

I HEREBY CONSENT FOR GEORGETOWN UNIVERSITY HOSPITAL PHYSICIANS TO OBTAIN MY MEDICATION PRESCRIPTION HISTORY AND PLACE MY PRESCRIPTION ORDERS THROUGH THE ELECTRONIC PRESCRIBING SYSTEM. **INITIALS:** **PT DECLINED** ☐

PHARMACY NAME: PHONE #: FAX #:

ADDRESS: CITY: ST: ZIP:

PLEASE GIVE YOUR INSURANCE CARDS TO OUR RECEPTIONIST TO PHOTOCOPY FOR OUR RECORDS. IF YOU ARE COVERED BY HMO INSURANCE, PLEASE GIVE YOUR REFERRAL TO OUR RECEPTIONIST.

*****AUTHORIZATION*****

I HEREBY AUTHORIZE ANY INSURANCE COMPANY, EMPLOYER, OR PHYSICIAN TO RELEASE INFORMATION REQUESTED WITH RESPECT TO CLAIMS FOR MY TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GEORGETOWN UNIVERSITY HOSPITAL PHYSICIANS, FOR BENEFITS THAT ARE OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

PATIENT SIGNATURE: **DATE:**

Joseph E. Coad Radiation Treatment Center

Patient Self-Assessment Questionnaire

Name: _____

Social History:

Your age: _____

Are you able to drive yourself to radiation: Yes No

Do you live alone? Yes No Primary Support Person: _____

Relationship status: Single Married Widowed Divorced Partnered

Occupation: _____ Do you work: Full-time Part-time On leave On disability

Have you been exposed to hazardous materials on your job? Yes No What material: _____

Do you smoke? Yes No If yes, for how long? _____ years _____ packs

If no, did you every smoke? Year quit _____

Do you drink? Yes No If yes, how often do you drink _____ What do you drink? _____

Do you currently use illicit (illegal) drugs? Yes No If yes what kind _____

Are you on a special diet? Yes No If yes, what kind of diet? _____

Do you speak any other language besides English? Yes No If yes, what language _____

How would you like us to communicate with you? Verbal Written Other _____

Religious or cultural concerns: _____

Do you have an advanced directive? Yes No **If Yes please provide office with copy**.

Would you like more information on an advanced directive? Yes No

Surgical History:

Please list **all surgeries** that you have had **in your lifetime including biopsies or port-a-cath insertion.**

Surgeries/Biopsies	**Year**

Medical History:

Please check if your medical history includes any of the following:

__ Diabetes __ High blood Pressure __ Arthritis __ Anemia
__ Seizures __ Thyroid Disease __ Cancer/Tumor __ Osteoporosis
__ Stroke __ Heart Disease __ Depression __ GERDS/ Stomach Ulcer
__ HIV __ Lung Disease/ Asthma __ Eczema/Rashes __ Immune Disease/ Lupus
__ STD __ Mental Illness __ Joint/Bone Pain __ Liver Disease/ Hepatitis
__ Scleroderma __ Kidney/Bladder Problems __ Prostate Problem __ Blood Clotting Problems
__ High Cholesterol ___ Other _____

Have you ever had a colonoscopy? Yes (Year_____) No

Check any of the following symptoms that you have had <u>within the last 3months.</u>

___ Sore throat
___ Hoarseness
___ Changes in speech
___ Swallowing problems
___ Sores in mouth
___ Deafness
___ Ear pain
___ Vision changes
___ Sinus problems
___ Cough
___ Cough up blood /phlegm
___ Shortness of breath
___ Wheezing
___ Using oxygen at home
___ Must sleep sitting up
___ Weakness / Dizziness
___ Fatigue
___ Sadness
___ Foley catheter

___ Heart Attack
___ Pacemaker
___ Defibrillator
___ Palpations/murmur
___ Chest pains
___ Easy bruising
___ Phlebitis / blood clots
___ Pains in legs when walking
___ Stomach pains
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Difficulty urinating
___ Urinary frequency
___ Seizures
___ Fainting
___ Fractures
___ Worry
___ Ostomy / Colostomy

___ Headaches
___ Numbness/tingling hands or feet
___ Difficulty Sleeping
___ Anxiety
___ Suicidal thoughts
___ Difficulty with memory
___ Depression
___ Fever
___ Chills
___ Sweats / Hot flashes
___ Changes in skin/nails
___ Weight loss (amount _____)
___ Weight gain (amount _____)
___ Increase thirst
___ Decrease appetite
___ Bone Pain / Joint Pain
___ Back Pain
___ Fears
___ Port a cath / Mediport

Please indicate if any of the following has been a problem for you in the past few weeks including today. Be sure to check YES or NO for each.

Yes No Child care
Yes No Housing
Yes No Insurance/ Financial
Yes No Work/ School
Yes No Transportation
Yes No Disease / treatment options
Yes No Physical problems

Yes No Dealing with partner/ family
Yes No Loss of interest in usual activities
Yes No Appearance
Yes No Bathing/ Dressing
Yes No Sexual Issues
Yes No Emotional problems
Yes No Spiritual / religious concerns

Circle the number that best describes how much distress you have been experiencing in the past few weeks including today based on the above problems you may be having.

0	1	2	3	4	5	6	7	8	9	10
No Distress		**Mild Distress**		**Moderate Distress**			**Extreme Distress**			**Worst Distress**

Have you fallen within the last 3 months? Yes No

For MEN Only

Do you get up frequently at night to urinate? Yes No How often ? _____
Do you wet your pants or wet the bed? Yes No
Do you have a weak or slow stream of urine? Yes No
Do you have difficulty starting your flow of urine? Yes No
Do you have difficulty getting or maintaining an erection? Yes No
Have you received hormone shots? Yes No
If yes to hormone shot, what was the name of shot _____ Date of last shot _____

For WOMEN Only

Date of your last menstrual period _____
Age of first menstrual period _____
Are you sexually active? Yes No
Are you currently on birth control? Yes No
If yes to birth control what was the name _____ How long on it? _____
Have you ever been on hormone replacement therapy? Yes No
If yes to hormone replacement therapy, what was the name _____ How long on it?_____
Are you in menopause? Yes No
Have you had a hysterectomy? Yes No
Do you perform self breast exams? Yes No
Year of your last mammogram? _____
Number of pregnancies _____ Age of first full term pregnancy _____
Number of children _____
Number of miscarriages _____
Number of stillbirth's _____
Number of abortions _____

Have you ever had radiation therapy before? Yes No
If yes, when_____, where _____, body part radiated _____

Have you ever had chemotherapy before? Yes No
If yes, date of last chemotherapy _____ What were you given? _____

Has anyone in your family ever had cancer? Yes No
If yes, please identify who and what kind of cancer:

Relative	**Type of Cancer**
Father	
Mother	
Grandfather(s)	
Grandmother(s)	
Brother(s)	
Sister(s)	
Aunt(s)	
Uncles(s)	
Children	

Do you have pain? YES NO If yes where? _____
If yes, rate your pain on the scale below:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN		MILD PAIN		MODERATE PAIN		MODERATE PAIN		SEVERE PAIN		WORST PAIN POSSIBLE

Do you have fatigue (tiredness)? Yes No
If yes, rate your fatigue on the scale:

0	1	2	3	4	5	6	7	8	9	10
NO FATIGUE		MILD FATIGUE			MODERATE FATIGUE			EXTREME FATIGUE		WORST FATIGUE POSS

Allergies / Medications

Do you have any allergies to drugs or products (tape)? Yes No

List Allergies	Reaction

Please list all medication that you are currently taking on a regular basis.
Include all vitamins and supplements.
***** You may attach a list if you have one.**

Medication	Dosage	How often

How did you hear about our office? _____

Patient signature: _____ Date_____

3/7/14

JOSEPH E. COAD RADIATION TREATMENT CENTER

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

THIS WILL AUTHORIZE YOU TO RELEASE INFORMATION CONCERNING:

PATIENT: _____ **DOB:** _____

REGARDING DATES: **FROM**: _____ **THROUGH**: _____

PLEASE RETURN TO:
Joseph E. Coad Radiation Treatment Center
7501 Surratts Road, Suite 108
Clinton, MD 20735

THIS AUTHORIZATION INCLUDES RELEASE OF THE FOLLOWING INFORMATION:

- ☐ 1. Consultations
- ☐ 2. Discharge Summaries
- ☐ 3. Pathology Reports / Pathology Slides

  Accession #: ☐ Accession #: ☐ Accession #: ☐
- ☐ 4. Radiology Reports (X-rays/CT Scans/MRI/PET, etc.)
- ☐ 5. Radiology Films
- ☐ 6. Nuclear Medicine Reports
- ☐ 7. Operative/Endoscopy Reports
- ☐ 8. Pulmonary Function Tests / Arterial Blood Gases

Other (specify): _____

The purpose of the release of this information is for evaluation and possible Radiation Therapy treatment and / or to determine appropriate mode of therapy.

I understand that I have the right to inspect and receive a copy of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.

I understand that I may specify a date for the expiration of this Authorization, but that it shall expire by law, without my express revocation, one year from the date written below, unless the patient is a resident of a nursing home. I direct that this authorization expire on _____, 20_____.

I understand it may be necessary to fax some information to another physician if required in my mode of treatment.

_____	_____	_____	_____
Social Security #	Date of Birth	Date	Signature of Patient

IF THE PATIENT IS NOT ABLE TO PROVIDE CONSENT TO THE RELEASE OF INFORMATION:

- _____
  Signature of person authorized to give consent

  _____
  Address

- STATE BASIS FOR AUTHORITY TO GIVE CONSENT ON PATIENT'S BEHALF:

  a) Medical care power of attorney, guardianship, court order, or letters of administration. (Attach copy)

  b) Relative or person authorized by law (explain relationship or legal authority)

This authorization must be signed by a party in interest as defined in Title 4 Subtitle 3 of the Health General Article of the Annotated Code of Maryland. In the case of a patient who is physically unable to sign this authorization, he or she should place an "X" on the signature line and have his or her assent witnessed.

_____ _____
SIGNATURE DATE

NOTICE
(TO ACCOMPANY RELEASE OF ALCOHOL AND DRUG ABUSE)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42. C.F.R. Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS