YUMA ONCOLOGY CENTER
PATIENT INFORMATION SHEET

Date: ______________________ **(PLEASE PRINT)** RECORD #: ________________

DR. GRADO * DR. VAKILIAN

Patient's FULL LEGAL Name: ____________________________________ SS# ____________________
Last *First* *Middle*

Mailing Address: ____ Phone: _____ - ______ - ________
PO Box/Apt or Space # *City/Province/State/Zip* Cell: _____ - ______ - ________

Permanent Address: ____ Fax: _____ - ______ - ________
Phone: _____ - ______ - ________

Temporary/Local Address: ____ Phone: _____ - ______ - ________
AT THIS ADDRESS UNTIL (DATE) ________________

E-Mail Address: ____________________ Birth Date ____/____/____ Age: _____ ☐ Male ☐ Female
Month *Day* *Year*

Employer: ____ Occupation: ________________

Address: ____ Phone: _____ - ______ - ________

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Spouse's Name: ____________________ SS # ________________ Birth Date: ___/___/___

Address: ____ Phone: _____ - ______ - ________

Spouses Employer: ____ Occupation: ________________

Address: ____ Phone: _____ - ______ - ________

RESPONSIBLE PARTY: ____

Birth Date: ___/___/___ SS # ________________ Relationship: ________________

Address: ____ Phone: _____ - ______ - ________

Emergency Contact: ____ Relationship: ________________

Address: ____ Phone: _____ - ______ - ________

Primary Care Physician: ____ Phone: _____ - ______ - ________

Address: ____ Fax #: _____ - ______ - ________

Referring Physician: ____ Phone: _____ - ______ - ________

Address: ____ Fax #: _____ - ______ - ________

ADVANCE DIRECTIVES—You have the right to prepare legal documents relating to: #1 your decision to refuse medical treatment you do not want; #2 requesting medical you do want; or #3 your ability to make medical decisions yourself.

Have you prepared any documents relating to the above 3 issues? ☐ YES ☐ NO
If yes, please provide a copy of the signed originals of the documents for inclusion in your medical files. .

I understand that by proceeding with services I am responsible for payment of this account. The balance due may include deductibles, office visits, co-payments or other services not paid by insurance or other amounts determined to be patient responsibility. In the event of default, I also understand that collection costs and/or attorney fees may be charged to effect collection. Co-payments are due at time of service. Balances are due at time of billing.

Signature: ____ Date: ________________
Patient or Responsible Party

INSURANCE INFORMATION

Please list all insurance coverage's which you expect to be filed for payment of services provided to you. If there are more than two insurance companies providing coverage, please request an additional form from our receptionist.

IF YOU CHANGE OR HAVE CHANGED INSURANCE COMPANIES, OR YOU BECOME ELIGIBLE FOR ANOTHER TYPE OF COVERAGE, PLEASE NOTIFY ONE OF OUR STAFF IMMEDIATELY!

Primary:

Insurance ______________________________

Address ______________________________

____
City/State/Zip

Phone ______________________________

Policyholder ______________________________

Relation to Patient ____________________ Date of Birth ____/____/____

Employer ______________________________

Policy ID # ____________________ Effective Date ____/____/____

Group ID # ____________________ Local #____________

Second:

Insurance ______________________________

Address ______________________________

____
City/State/Zip

Phone ______________________________

Policyholder ______________________________

Relation to Patient ____________________ Date of Birth ____/____/____

Employer ______________________________

Policy ID # ____________________ Effective Date ____/____/____

Group ID # ____________________ Local # ____________

Prior Authorization Required? ☐ YES ☐ NO

Hospital Coverage Only? ☐ YES ☐ NO

Applied for AHCCCS/Medicaid? ☐ YES ☐ NO

Are You Eligible for Medicare? ☐ YES ☐ NO

Do You Have Medicare Part A Only? ☐ YES ☐ NO

Medicare Replacement HMO Policy? ☐ YES ☐ NO

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize *Southwest Oncology LLC, dba Yuma Oncology Center, Dr. Gordon Grado, and Dr. Siavosh Vakilian,* to furnish information to my insurance carrier(s) concerning my illness and treatments.

I hereby assign payment direct to *Southwest Oncology LLC, dba Yuma Oncology Center,* the surgical and/or medical benefits otherwise payable to me under the terms of my insurance. I understand that I am responsible for any amount not covered by insurance and that balances are due upon receipt of billing.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

Signature: ______________________________ **Date:** ____________________
Patient or Responsible Party

MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to *Southwest Oncology LLC, dba Yuma Oncology Center,* for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Name: ______________________________ **ID #:** ____________________

Signature: ______________________________ **Date:** ____________________
Patient or Responsible Party

I authorize the Medicare Claim Administration to release to *Southwest Oncology LLC, dba Yuma Oncology Center,* claim information for services provided to me by the above named provider(s).

Medicare # ______________________________ **Retired Railroad?** ☐ YES ☐ NO

Hospital (Plan A) _____ **Effective Date:** ____/____/____ **Medical (Plan B)** _____ **Effective Date:** ____/____/____

RECORDS/FILM REQUEST – AUTHORIZATION FOR RELEASE OF INFORMATION

Yuma Oncology Center

RADIATION ONCOLOGY / TOMOTHERAPY / BRACHYTHERAPY
GORDON L. GRADO, M.D., FACRO, FACR
SIAVOSH VAKILIAN, M.D.

1951 W. 25TH STREET, SUITE F
YUMA, AZ 85364
TEL(928) 317-9200
FAX(928) 317-9205
www.yumaoncologycenter.com

____

Patient Name Medical Record No. Date of Birth

I authorize:
☐ Gordon L. Grado, MD ☐ Siavosh Vakilian, MD ☐ ________________________.
to: ☐ Obtain information from my medical record from:
☐ Release information from my medical record to:

____

Name Phone No. Fax No.

____

Address City State Zip Code

Please provide the following information from my medical record:
- ☐ Duplicate Copy of my medical record:
- ☐ Other:____

I hereby consent to the release of records pertaining to treatment/diagnosis of the following:
- ☐ Confidential Alcohol or Drug Abuse – Related Information
- ☐ Confidential HIV – Related Information
- ☐ Confidential Mental Health Diagnosis/Treatment Information
- ☐ Confidential Communicable Disease – Related Information

Except as follows:____

The purpose of this request is for:
- ☐ Further Medical Care
- ☐ Legal
- ☐ Insurance
- ☐ Disability/Workman's Comp
- ☐ Radiology – All films are the property of the clinic and must be returned within 30 days
- ☐ Other____

I understand that this authorization shall expire, without my express revocation, six (12) months from the date written below, [sixty (60) days for drug/alcohol treatment records]. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

____ Date:______________________

Patient Signature

____ Date:______________________

Legal Representative Signature

____

PRINT: Legal Representative Relationship

____

Signature of Witness Information Prepared and Released by Date Released

Where Experience and Technology Meet

MEDICATION HISTORY RETRIEVAL

We have a great tool that will allow us to electronically obtain your medication history to ensure that our records are complete. We use Sure Scripts to provide medication histories when your medication is obtained from most major pharmacies. However, in order to obtain this information we need your approval. Please check yes that you would like us to obtain that information.

_____ Yes please obtain my medication history.

_____ No you may not obtain my medication history.

______________________________ ____________

Patient Signature Date

____

Print Patient Name

In addition, we can send your prescription needs to your pharmacy electronically. However, to be able to do this we require the name and location of your pharmacy.

____

Pharmacy Name

____

____

Address, City, State Zip

____

Pharmacy Telephone Number

HIPPA (HEALTH INSURANCE PORTABILITY ACT OF 1996 NOTICE OF PRIVATE PRACTICES

DATE_______________________________ JKT#_______________________________

NAME_______________________________ SIGNATURE_______________________________

DOB_______________________ WITNESS /STAFF ONLY_______________________________

WITH THIS DOCUMENT I GIVE CONSENT TO YUMA ONCOLOGY CENTER TO DISCLOSE INFORMATION ABOUT MY HEALTH INFORMATION TO.

NOTICE OF PRIVACY PRACTICES
To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability Act of 1996 (HIPPA).

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and Safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the treat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

With my signature I testify that I received a copy of HIPPA Information Sheet and Patient Rights.

Patient's Rights

Yuma Oncology Center ensures that patients have these rights.

A patient will be treated with dignity, respect, and consideration. A patient will not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, restraint or seclusion (except as allowed in R9-10-1012(B)), retaliation for submitting a complaint to the Department or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer or student.

A patient or the patient's representative, except in an emergency, either consents to or refuses treatment. A patient or the patient's representative may refuse or withdraw consent for treatment before treatment is initiated. Except in an emergency, a patient or the patient's representative is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure (not used or performed at this facility). A patient or the patient's representative is informed of the outpatient treatment center's policy on health care directives and the patient complaint process. A patient or the patient's representative consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes. A patient or the patient's representative, except as otherwise permitted by law, provides written consent to the release of information in the patient's medical record or financial records.

A patient has the right not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis. A patient has the right to receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities. A patient has the right to receive privacy in treatment and care for personal needs. A patient has the right to review, upon written request, the patient's own medical record according to A.R.S. 12-2293, 12-2294, and 12-2294.01. A patient has the right to receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient. A patient has the right to participate or have the patient's representative participate in the development of, or decisions concerning, treatment. A patient has the right to participate or refuse participation in research or experimental treatment. A patient has the right to receive assistance from a family member, the patient's representative, or other individual in understand, protecting, or exercising the patient's right.

HIPPA (HEALTH INSURANCE PORTABILITY ACT OF 1996 **NOTICE OF PRIVATE PRACTICES**

DATE________________________________**JKT#**____

NAME________________________________**SIGNATURE**___________________________________

DOB__________________________ **WITNESS /STAFF ONLY**________________________________

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1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and Safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the treat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

With my signature I testify that I received a copy of HIPPA Information Sheet and Patient Rights.