Premier
Cancer Care and Infusion Center

7065 N. Maple Ave Suite 102
Fresno, CA 93720
Phone: 559-554-2100
Fax: 559-554-2114

PATIENT REGISTRATION INFORMATION

OFFICE HOURS
Monday- Friday 8:00 a.m. to 5:00 p.m.

APPOINTMENTS

To Schedule	Call (559) 554-2100
Reminder	You will receive a phone reminder two days before your appointment.
Cancellation	Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $25 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hour notice. If you are more than 30 minutes late to an appointment, the appointment may be rescheduled.

FINANCIAL & INSURANCE INFORMATION

INSURANCE
Premier Cancer Care and Infusion Center is contracted with most insurance plans. Our staff will make a good faith attempt to determine benefit levels and estimate any charges you may incur. However, it is ultimately your responsibility to understand your level of coverage from your insurance company. It is your responsibility to supply us with appropriate billing information, which includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit", you will be held financially responsible for these charges.

PAYMENT
Unless prior arrangements are made all copayments, deductibles and share of costs are due at the time of service. For your convenience our office accepts cash, checks, and credit card.

FORMS
We will gladly complete your disability forms, however, please allow 72 hours for completion. A fee of $ 25.00 will be collected prior to completion for each form; and $15.00 for each generated letter.

AFTER HOURS CARE
If you have a medical emergency, please call 911. If you have a non-emergent question or need, you may call our office and the phone service will contact the physician on call.

CANCELLATIONS
We realize that unforeseen circumstances might make it impossible for you to keep your appointment. If this should occur, we ask that you kindly call our office 24 hours prior to your appointment and reschedule for a more convenient time. If you fail to show up for a scheduled appointment you will be charged $25.00.

I have read and agree to the financial & insurance information above

Name_____ Date _____

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First	Middle	Last	Nick Name	Marital Status S M W

Street Address	City & State	Zip	Primary Phone Number ( )	H M

Date of Birth	Age	Sex	Social Security No. - -	Secondary Phone ( )	Business Phone ( )

Patient's Employer (Name)	Patient's Occupation	Ethnicity	Race
		☐ Hispanic or Latino ☐ NOT Hispanic or Latino	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other
E-mail Address	Preferred Language		

Spouse's Name	Spouse Date of Birth	Spouse Social Security No.	Spouse Phone No

Spouse's Employer (Name)	Spouse Occupation	Spouse Business Phone No.

EMERGENCY CONTACT: (Friend, Neighbor, Relative not living in the home)	Relationship	Phone Number ( )

Referring Physician	Primary Care Physician	Primary Care Physician Phone ( )

PRIMARY INSURANCE	Insurance Carrier	
ID No.	Group No.	Effective date
Primary Cardholder's Name	Primary Cardholder Social Security #	Primary Cardholder Date of Birth
Primary Cardholder's Employer		

SECONDARY INSURANCE	Insurance Carrier	
ID No.	Group No.	Effective date
Secondary Cardholder's Name	Secondary Cardholder Social Security #	Secondary Cardholder Date of Birth
Secondary Cardholder's Employer		

If Medicare is secondary, please indicate why: Working age (Patient or Spouse) Disability ESRD Other: _____

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CONSENT AND RELEASE OF INFORMATION

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent of such treatment. I hereby give consent for release of medical information to consulting physician and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred.

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to auhorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

_____ _____

Patient/Responsible Party Signature Date

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PATIENT RECORD OF DISCLOSURE

This information will help us communicate with you effectively and protect your privacy. No person automatically has the right to receive your medical treatment and care information, including your spouse, children, etc. Please list the people you give permission to receive information regarding your medical treatment and care:

Name _____ Relationship _____

Phone _____ ❑ Home ❑ Cell ❑ Work

Name _____ Relationship _____

Phone _____ ❑ Home ❑ Cell ❑ Work

Name _____ Relationship _____

Phone _____ ❑ Home ❑ Cell ❑ Work

Your Healthcare Providers

There are times when Premier Cancer Care and Infusion Center will need to request reports and health information from your other physicians and /or medical centers for your care. In order to do so, your authorization is required.
I authorize the use, request and/or disclosure of my protected health information. I understand that the information used or disclosed as a result of the authorization may no longer be protected by federal privacy laws and may be further used or disclosed to persons or organizations receiving it without obtaining my authorization. I have the right to revoke this authorization by providing written notice to Premier Cancer Care and Infusion Center.

Patient Name _____

Patient Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Premier Cancer Care and Infusion Center.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or other health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all protected health information that we maintain. Upon your request we will provide you with a copy of our revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

I. Permitted Uses and Disclosures of Protected Health Information

- Treatment: Your physician will use or disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities that your health plan may undertake before it approves or pays for health care services that we recommend for you. These activities include: determining eligibility, reviewing services for medical necessity, and utilization review activities.

- Health Care Operations: We may use or disclose your protected health information to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the front desk where you will be asked to sign your name and indicate your physician, we may call you by name in the waiting room when your physician is ready to see you, or we may use your information as necessary, to contact you to remind you of an appointment.

- Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for health care providers to access when it is determined that you require emergent care.

II. Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent we have relied on the use or disclosure of protected health information indicated in the authorization.

III. Permitted Uses and Disclosures Without Your Authorization or Opportunity to Object

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs and medical devices.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Healthy Oversight: We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to a subpoena or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. For example, to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.

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Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes or to determine the cause of death; to a funeral director, as authorized by law, to aid in burial; or to organizations that handle organ and tissue donations.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: We may use or disclose your protected health information to prevent a serious threat to health or safety.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Business Associates: We may disclose your protected health information to third party "business associates" who perform health care operations for us and who agree to keep your health information private.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

IV. Patient Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request access or a copy of your protected health information. You may request access and/or a copy of your medical information maintained in our records, including medical and billing records. Your request must be in writing. Following is our fee schedule for copying medical records:

Patient Request: $25.00 per copy of record

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We do not have to agree to the request, however if we do, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. You may
request a restriction by completing a "Restriction Request Form" available at the front desk. You will receive a response in writing within seven (7) days of receiving your request.

Your physician may deny the restriction request if he/she believes it is in your best interest to permit the use and disclosure of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You have the right to request an amendment to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us from which we may prepare a rebuttal. We will provide you with a copy of any such rebuttal. Please fill out an "Amendment Request Form" available at the front desk if you would like to request that an amendment be made to your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or pursuant to a valid authorization as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

V. Complaints

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our Corporate Privacy Officer, M. Mansoor Alam, MD at (559) 554-2100 or by e-mail at malam@pccaic.com. You may also send a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102
1-415-437-8310

Premier Cancer Care and Infusion Center. will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

This notice was published and becomes effective on January 1, 2014

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PATIENT HEALTH INFORMATION

Name _____ Date of Birth _____/_____/_____

Referring MD _____ Primary Care Physician _____

Medical History (please circle)

☐ Cardiac disease ☐ High blood pressure ☐ Kidney disease ☐ Thyroid disease

☐ Lung Disease ☐ Diabetes ☐ Liver disease ☐ Other _____

Current Medications and dosage Include aspirin, blood thinners, and any herbal medications

_____ _____ _____

_____ _____ _____

Medication allergies (penicillin, Sulfa, Morphine, Demerol, etc.) Latex allergy ❑ Yes ❑ No

_____

Past Surgeries (include approximate year if known)

_____ _____ _____

_____ _____ _____

Past Hospitalization for illness (include approximate year if known)

_____ _____ _____

_____ _____ _____

HEALTH MAINTENANCE

Please provide date or answer none

Last mammogram _____ Last colonoscopy _____

Last Pap smear _____ Last bone density _____

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PATIENT HEALTH INFORMATION **Patient Name:** _____

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No How many years?_____# Packs per day?_____When did you quit? _____

Do you drink alcohol? ❑ Yes ❑ No How often? ❑ Daily ❑ Weekly

How much time do you spend exercising each week?_____What type of exercise? _____

Marital Status: ❑ Married (how long__) Spouse's Occupation_____❑ Single ❑ Divorce ❑ Widow ❑

Other Number of children_____Ages _____

Profession_____❑ Currently Working ❑ Retired ❑ Disabled

Birth location_____

Are you or a family member of Ashkenazi Jewish descent? ❑ Yes ❑ No

FAMILY HISTORY

If there is family history of cancer, blood disorder, cardiovascular disease, or other medical problems? If so, record below

m= Maternal p=Paternal

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	❑ Living ❑ Deceased		Grandmother (p)	❑ Living ❑ Deceased	
Father	❑ Living ❑ Deceased		Grandfather (p)	❑ Living ❑ Deceased	
Children	❑ Living ❑ Deceased		Aunt (s)	❑ Living ❑ Deceased	
Brother (s)	❑ Living ❑ Deceased		Uncle (s)	❑ Living ❑ Deceased	
Sister (s)	❑ Living ❑ Deceased		Cousin (s)	❑ Living ❑ Deceased	
Grandmother (m)	❑ Living ❑ Deceased		Other	❑ Living ❑ Deceased	
Grandfather (m)	❑ Living ❑ Deceased				

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PATIENT HEALTH INFORMATION **Patient Name:**

REVIEW OF SYMPTOMS
Please check off any symptoms you are experiencing.

General
- Fever/Chills ☐
- Night Sweats ☐
- Fatigue ☐
- Weight Changes ☐

Skin
- Skin Cancer ☐
- Rash ☐
- Change in mole ☐
- Persistent Itching ☐
- Bruise easily ☐

Head, Ears, Eyes, Nose and Throat
- Glasses ☐
- Dizziness ☐
- Vertigo ☐
- Hearing Loss ☐
- Headaches ☐

Cardiac
- Chest pain/angina ☐
- Palpitations ☐
- High blood pressure ☐
- Edema/swelling ☐

Respiratory
- Frequent Coughs ☐
- Asthma ☐
- Shortness of breaths ☐
- Tuberculosis ☐

Gastrointestinal
- Heartburn ☐
- Nausea/Vomiting ☐
- Diarrhea ☐
- Constipation ☐
- Change in stools ☐
- Diverticulitis ☐
- Irritable bowel ☐

Urinary
- Urine retention ☐
- Incontinence ☐
- Frequency ☐
- Blood in Urine ☐

Hematologic
- Prior blood transfusion ☐
- How many units? _____ ☐
- Blood clotting problem ☐
- Excessive bleeding with injuries ☐

Neurological
- Seizures ☐
- Stroke ☐
- Tremor ☐
- Fainting ☐

Psychological
- Depression ☐
- Anxiety ☐
- Insomnia ☐

Musculoskeletal
- Arthritis ☐
- Back pain ☐
- Fibromyalgia ☐

Endocrine
- Too hot/ Too cold ☐
- Excessive weight gain/loss ☐
- Dry skin ☐
- Diabetes ☐

FOR BREAST PATIENTS/WOMEN ONLY

Number of pregnancies _____ Number of live births _____ Age of first live birth _____

Age of first period _____ Date of last period _____

Did you breast feed? ❑ Yes ❑ No How long? _____ Bra cup size _____

Have you used hormone replacement or birth control pills/injections (circle) for how long? _____