CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

Gary E. Campbell, MD Celine B. Ord, MD

Diplomates, American Board of Radiology

Sandra L. Shirley, PA-C

TODAY'S DATE: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Place of Birth _____ Social Security _____

Marital Status: ___Married ___Divorced ___Single ___Widowed ___Other Ethnicity _____

Mailing Address _____ City _____ State____ Zip Code_____

Home Phone # _____ Cell Phone # _____

Local address during treatment if different than home _____

Email Address _____ Preferred Pharmacy _____

Employer _____ Occupation _____

Employer Address _____ Work Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

Referring Physician _____ Primary Care Physician _____

Other Current Physicians _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Name of Insured _____

ID Number _____ Relationship to Insured _____

Secondary Insurance Carrier _____ Name of Insured _____

ID Number _____ Relationship to Insured _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Carson-Tahoe Radiation Oncology Associates for the medical benefits for services rendered. I hereby authorize Carson-Tahoe Radiation Oncology Associates to release all information necessary to process this claim.

SIGNED _____ **DATE** _____

1535 Medical Parkway, Suite A
Carson City, Nevada 89703
Telephone 775-883-5505 FAX 775-883-6779

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

CURRENT REVIEW OF SYSTEMS

Name: _____ Date _____

Please check each item "yes" or "no" as they relate to your health in the last six months:

CONSTITUTIONAL:	**YES**	**NO**
Weight loss	___	___
Fatigue	___	___
Fever	___	___
EYES:		
Glasses/Contacts	___	___
Double vision	___	___
Cataracts	___	___
EARS, NOSE, THROAT:		
Difficulty hearing	___	___
Ringing in ears	___	___
Vertigo	___	___
CARDIOVASCULAR:		
Chest pain	___	___
Dizziness	___	___
Shortness of breath	___	___
Difficulty lying flat	___	___
Swelling of ankles	___	___
Pacemaker/Defibrillator	___	___

RESPIRATORY:	**YES**	**NO**
Cough	___	___
Coughing Blood	___	___
Wheezing	___	___
GASTROINTESTINAL:		
Heartburn/Reflux	___	___
Nausea/Vomiting	___	___
Constipation	___	___
Change in BM's	___	___
Diarrhea	___	___
Abdominal pain	___	___
Black or bloody BM	___	___
GENITOURINARY:		
Burning/Frequency	___	___
Blood in urine	___	___
Erectile dysfunction	___	___
Bladder leakage	___	___

MUSCULOSKELETAL:	**YES**	**NO**
Joint pain/Swelling	___	___
SKIN:		
Rash/Sores	___	___
Itching/Burning	___	___
NEUROLOGICAL:		
Loss of strength	___	___
Numbness	___	___
Headaches	___	___
PSYCHIATRIC:		
Anxiety/Depression	___	___

Date of last Colonoscopy: _____

Patient MEDICAL History

Diabetes	___ Yes ___ No
Hypertension	___ Yes ___ No
Cancer	___ Yes ___ No
Stroke	___ Yes ___ No
Heart trouble	___ Yes ___ No
Arthritis/Gout	___ Yes ___ No
Depression	___ Yes ___ No

Patient FAMILY History

	Mother	**Father**
Diabetes	___ Yes ___ No	___ Yes ___No
Hypertension	___ Yes ___ No	___ Yes ___ No
Cancer	___ Yes ___ No	___ Yes ___ No
Stroke	___ Yes ___ No	___ Yes ___ No
Heart Trouble	___ Yes ___ No	___ Yes ___ No
Arthritis/Gout	___ Yes ___ No	___ Yes ___ No
Depression	___ Yes ___ No	___ Yes ___ No

Patient SOCIAL History

Marital Status: ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed ___

Use of Alcohol: ___ Yes ___No ___ 1-2 per day ___ 3-5 per day ___ +5 per day

Use of Tobacco: ___ Yes ___ No If yes: ___ Current ___ Former

Type: ___ Cigarettes ___Vape ___ Chew

How much: ___ 1-5 per day ___ 5-10 per day ___ 1 pack per day ___ 2 packs per day ___ Other

How long have you used tobacco? _____

Use of Drugs: ___ Yes ___ No ___ Never Type/Frequency: _____

Have you been vaccinated for COVID? ___ Yes ___ No

Have you had a FLU shot? ___ Yes ___ No

Please list any ALLERGIES below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list ALL MEDICATIONS AND SUPPLEMENTS below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient's Signature _____

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PATIENT AUTHORIZATION FORM

Patient Name: _____

It is the policy of Carson-Tahoe Radiation Oncology Associates (CTROA) to make confirmation phone calls to patients on the day before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items.

Please see below and mark accordingly:

My appointments	**YES**	**NO**
My medical care	**YES**	**NO**
My patient account	**YES**	**NO**

Also, if I am not available, I authorize the staff to speak with the following individuals regarding my care.

Name of Individual	**Relationship to Patient**	**Phone Number**

I authorize the staff of CTROA to call my work number if I am otherwise not available. YES NO

I authorize the staff of CTROA to leave a message on my voicemail at home or at work. YES NO

I understand that it is the policy of CTROA to take a photo of each patient for their chart.

_____ _____

Patient Signature **Date**

Rev. 02/2023

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Sandy L. Shirley, PA-C

I, _____, authorize the release of my medical records, including face sheet, demographics, insurance information, doctor notes, history and physical, x-ray reports, labs, operative and/or biopsy reports, and pathology to **CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES.**

I also authorize the release of my medical records from **CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES** to doctors I may be referred to.

Patient Name: _____ Date: _____

Date of Birth: _____

Patient Signature: _____

Guardian or POA Signature: _____

Name Guardian or POA (Printed): _____

1535 Medical Parkway, Suite A, Carson City, Nevada 89703

Telephone: 775-883-5505 Fax: 775-883-6779

CARSON TAHOE
Radiation Oncology Associates

CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

Diplomates, American Board of Radiology

Billing Address: P.O. Box 306066, Nashville, TN 37230-6066

Dear Patient:

Thank you for choosing us as your healthcare provider. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to call our business office. The following is our Financial Policy.

We ask that all patients read and sign our Financial Policy as well as complete a Patient Information Form on your first visit.

Payment for services can be made in several different ways. We accept CASH, CHECK, or CREDIT CARD payments. We will process your insurance claim for your reimbursement if you provide us with the necessary insurance information.

Please inform our business office of any insurance changes, address changes and telephone changes.

1. Your insurance policy is a contract between you, your employer and the insurance company. We ARE NOT parties to that contract. Our relationship is with you, the patient, not your insurance company. However, we will bill your insurance company as a courtesy to you.

2. All charges are YOUR responsibility whether your insurance company pays or not. Most services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover, or cover at a lesser percentage.

3. Medicare patients without a secondary insurance and patients who do not have insurance will be asked to make partial payments at the time of service.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our business office so that we can assist you in the management of your account. If a payment plan is needed or any other assistance required, please feel free to call our business office.

Again, thank you for choosing us as your healthcare provider. We appreciate your trust in us and welcome the opportunity to serve you.

_____ _____

PATIENT SIGNATURE **DATE**

Rev. 02/2023

CARSON TAHOE
Radiation Oncology Associates

Acknowledgement of Receipt of Notice

CARSON TAHOE RADIATION ONCOLOGY ASSOCIATES

Privacy Officer: Cindy Gonsalez (775)883-5505

I hereby acknowledge that I received a copy of this medical practices Notice of Privacy Practices.

SIGNED*: _____ Date: _____

Print Name: _____ Phone: _____

***If not signed by the patient, please indicate relationship: _____**

_____

For office use only:

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of this medical practices Notice of Privacy Practices.

Name of Patient: _____

Reason for refusal: _____

_____

_____ _____

Employees Signature Date

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Carson City, Nevada 89701
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