CPRCC Charlotte Hall Office
30077 Business Center Drive
Charlotte Hall, Maryland 20622

# CHESAPEAKE POTOMAC REGIONAL CANCER CENTER
# REGISTRATION FORM

(Please Print)

CPRCC Waldorf Office
11340 Pembrooke Sq, Suite 201
Waldorf, Maryland 20603

Today's date:

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| ❑ Mr.<br>❑ Mrs. | ❑ Miss<br>❑ Ms. | Patient's First Name: | Middle: | Last: | |
| Street address: | | City: | State | Zip Code: | |
| Mailing address: | | City: | State | Zip Code: | |
| Gender:<br>❑ M ❑ F | Race (check all that apply) : ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other | | | | |
| Home Phone:<br>( ) | Work Phone:<br>( ) | Mobile Phone:<br>( ) | Home Fax:<br>( ) | | |
| Email: | Social Security Number: | Date of Birth: | Preferred Method of Contact:<br>❑ Phone ❑ US Postal<br>❑ Email: | | |
| Preferred Language: | | Ethnicity:<br>❑ Hispanic or Latino<br>❑ Not Hispanic or Latino | Marital status (circle one)<br>Single / Mar / Div / Sep / Widow | | |
| Employer: | Employer Address: | | Employer phone no.:<br>( ) | | |
| Occupation: | Advance Directive and/or Medical Power of Attorney: ❑ Yes ❑ No | | | | |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Spouse's Name: | | Home phone :<br>( ) | Work phone :<br>( ) |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone :<br>( ) | Work phone :<br>( ) |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Referring Physician: | Contact Number: |
| Surgeon: | Contact Number: |
| Medical Oncologist: | Contact Number: |
| Family/Primary Care Physician: | Contact Number: |

| | |
|---|---|
| Previous Radiation Therapy:<br>❑ Y ❑ N | Facility Name and Contact Number: |

**Insurance Subscriber Name:** **Subscriber Date of Birth:** \ \

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chesapeake Potomac Regional Cancer Center or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

## PRESCRIPTION HISTORY AUTHORIZATION

I authorize Chesapeake Potomac Regional Cancer Center to download my electronic prescription history.

*Patient/Guardian signature* *Date*

**Patient Name:** _____ **DOB:**_____

**Pharmacy Name:**_____**Location:**_____**Phone:** _____

- **Are you Diabetic? Yes No**
- **Do you have Renal Failure? Yes No**
- **Do you have Asthma? Yes No**
- **Are you allergic to Iodine or Seafood? Yes No**

**Allergies: (Medications, foods, environmental, etc.)**_____

_____

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## Current Medications

| Medication Name | Dose | Frequency | Reason for Taking |
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## Vitamins, Herbal or Nutritional Supplements

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**Patient Name:**_____ **DOB:**_____

**PLEASE CHECK OFF ANY OF THE SYMPTOMS BELOW THAT YOU HAVE HAD IN THE PAST 2 MONTHS**

**BREAST/GENITAL**
- Mass on self-exam
- Discharge

**BLOOD/LYMPH**
- Unusual bruising
- Bleeding gums

**CARDIOVASCULAR**
- Palpitations
- Chest pain
- Pacemaker
- Leg pain with walking
- Ankle swelling

**CONSTITUTIONAL**
- Weight loss

lbs.___over_ mos.
- Weight gain

lbs.___over_ mos.
- Change in appetite
- Tub Feeding

_____cans per day

_____supplement
- Fevers
- Sweats
- Fatigue
- Dizziness
- Weakness
- Use a walker
- Use a cane
- Use a wheelchair

**DENTAL**
- Dentures
- Crowns
- Nose bleeds

Last dental exam/cleaning

_____

**ENDOCRINE**
- Excessive thirst
- Known thyroid problem
- Feel too hot/cold
- Diabetes

**EARS, NOSE AND THROAT**
- Nose bleeds
- Dizziness
- Loss of hearing
- Jaw pain

**EYES**
- Blurry vision
- Double vision
- Glaucoma
- Cataracts

**GASTROINTESTINAL**
- Difficulty swallowing
- Difficulty chewing
- Nausea/vomiting
- Diarrhea/constipation
- Dark, tarry stools
- Blood in stools
- Reflux

**GYNECOLOGIC**

Age at first pregnancy _____
Pregnancies _____
Live births _____
Age of first menarche _____
Menopause _____
Hormone use Y N
Last Pap smear _____
Last menstrual period
Last Mammogram _____
Last BSE _____
Pregnant Y N
Sexually active Y N

**MUSCULOSKELETAL**
- Joint pain
- Gout
- Arthritis

**NEUROLOGIC**
- Weakness
- Headaches
- Dizziness
- Seizures/convulsions
- Numbness

**PSYCHIATRIC**
- Depression
- Anxiety
- Mood changes

**RESPIRATORY**
- Short of breath
- Short of breath on exertion
- Wheezing
- Cough
- Coughing up blood
- Coughing up
- Phlegm

**SKIN**
- New rash
- Sensitivity to sun
- Change in the size or color of a lesion

**URINARY SYSTEM**
- Difficulty urinating
- Difficulty controlling the bladder
- Getting up at night to urinate
- Burning with urination
- Blood in urine
- Kidney Disease/Dialysis

CHESAPEAKE POTOMAC
REGIONAL CANCER CENTER

# Insurance Information

**Primary Insurance**

Patient's Name:_____ Date of Birth:_____

Subscriber's Name:_____ Date of Birth:_____

Primary Insurance Co. Name: _____

Primary Insurance Co. Address: _____

Insurance Co. Address: _____

Policy ID Number:_____Group:_____Code:_____

**Secondary Insurance**

Patient's Name:_____ Date of Birth:_____

Subscriber's Name:_____ Date of Birth:_____

Secondary Insurance Co. Name: _____

Secondary Insurance Co. Address: _____

Insurance Co. Address: _____

Policy ID Number:_____Group:_____Code:_____

## Assignment and Authorization Agreement

This is to certify that I hereby authorize Associates in Radiation Medicine to apply for benefits for services rendered to me by the above physician/physician group. I request payments from and insurance or reimbursing agency to be made directly to Associates in Radiation Medicine/CPRCC (or in the case of Medicare Part B, benefits to myself or the third party who accepts assignment).

I certify that the information I have provided concerning my insurance coverage is correct. I further authorize the release of any information, including medical information, for this or any related claims to any insurance company nor reimbursing agency (or in the case of Medicare Part B, benefits to Social Security Administration and Health Care Financing Administration) in order to determine benefits to which I may be entitled.

Any reimbursing insurance agency or myself may revoke this authorization in writing at any time. I permit a copy of this authorization be used in place of the original as needed.

Patient/Beneficiary Signature:_____Date:_____

**This Document is Valid for 1 Year**

CHESAPEAKE POTOMAC
REGIONAL CANCER CENTER

# RECORDS REQUEST FORM

Patient's Name: _____ DOB: _____

Patient's MRN: _____ SSN: _____

Date: _____ (This Request is valid for 1 year)

To: _____

*I hereby authorize and request you to release the following medical records in your possession, concerning my cancer diagnosis and/or treatment:*

Date of Procedure

- ☐ X-Rays, CT scans, MRI, etc. Films & Reports _____
- ☐ Pathology Report _____
- ☐ Consultation/Discharge/Follow-Up Notes _____
- ☐ Surgical and Operative Reports _____
- ☐ Previous Radiation Therapy Records _____
- ☐ Lab Reports (including PSA if applicable) _____
- ☐ Other _____

**Please Fax or Mail to:**

**☐Charlotte Hall Office:**
**30077 Business Center Drive**
**Charlotte Hall, MD 20622**
Phone: 301-884-2508
**Fax: 301-884-2476**

**☐Waldorf Office:**
**11340 Pembrooke Square #201**
**Waldorf, MD 20603**
Phone: 301-705-5802
**Fax: 301-843-1704**

Thank You!

Patient Signature: _____ (if relative, state relationship) _____

Requested by (initials): _____

# ASSOCIATES IN RADIATION MEDICINE
# MEDICAL INFORMATION AND INSURANCE CONSENT

**Payment and Billing:** I request that payment for all covered benefits regarding any services furnished to me by Associates in Radiation Medicine be made to Associates in Radiation Medicine. I understand that Associates in Radiation Medicine shall bill an appropriate insurer or third-party payer when appropriate as a courtesy to me. I authorize any holder of Protected Health Information to release to the Centers for Medicare and Medicaid Service and its agents or my insurance company any information needed to determine benefits which may be available. The fact that I may have insurance does not determine benefits which may be available. The fact that I may have insurance does not release me of my personal responsibility for payment. I agree to be responsible for payment for payment of charges for services rendered to me by Associates in Radiation Medicine that are not otherwise covered or paid for by Medicare or any other health insurance plan I may have. I hereby agree that in the event I receive payment directly from any health insurer or other payor that I will immediately forward the amount of such payment due on my account to Associates in Radiation Medicine or its authorized signee.

**Please Note:** Lack of accurate insurance information and/or demographic information (D.O.B., address, phone number, social security number) may prevent payment by certain insurance companies; in these instance patients are responsible for all balances. I agree to provide all information requested and ensure the accuracy of this information and understand that I am responsible for payment if payment is denied due to lack of or incorrect information.

Print Name: _____ Date: _____

Patient Signature: _____
(or Authorized Agent Signature)

**Chesapeake Potomac Regional Cancer Center**


**Charlotte Hall**
30077 Business Center Drive
Charlotte Hall, Maryland 20622
Phone: 301-884-2508
Fax: 301-884-2476

**Waldorf**
11340 Pembrooke Square, Suite 201
Waldorf, MD 20603
Phone: 301-705-5802
Fax: 301-843-1704


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## HIPPA NOTICE OF PRIVACY

**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 DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND

HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**CPRCC is required by law to:**

1. Maintain the privacy of protected health information
2. Give you this notice of our legal duties and privacy practices regarding health information about you
3. Follow the terms of our notice that is currently in effect

**HOW CPRCC MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways CPRCC may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, CPRCC will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

**For Treatment**. CPRCC may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, CPRCC may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**For Payment**. CPRCC may use and disclose Health Information so that CPRCC or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, CPRCC may give your health plan information about you so that they will pay for your treatment.

**For Health Care Operations**. CPRCC may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the radiation therapy you receive is of the highest quality. CPRCC may also share information with other entities that have a relationship with you (for example, your medical oncologist) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services**. CPRCC may use and disclose Health Information to contact you to remind you that you have an appointment with us. CPRCC may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care**. When appropriate, CPRCC may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research**. Under certain circumstances, CPRCC may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, CPRCC may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:**

**As Required by Law**. CPRCC will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety**. CPRCC may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates**. CPRCC may disclose Health Information to CPRCC business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, CPRCC may use another company to perform billing services on our behalf. All CPRCC business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation**. If you are an organ donor, CPRCC may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Military and Veterans**. If you are a member of the armed forces, CPRCC may release Health Information as required by military command authorities. CPRCC may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation**. CPRCC may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks**. CPRCC may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. CPRCC will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities**. CPRCC may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** CPRCC may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, CPRCC may disclose Health Information in response to a court or administrative order. CPRCC may also disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement**. CPRCC may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors**. CPRCC may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. CPRCC may also release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities**. CPRCC may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others**. CPRCC may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**Inmates or Individuals in Custody**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, CPRCC may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to

provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT**

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object, CPRCC may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, CPRCC may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

**Disaster Relief.** CPRCC may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. CPRCC will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**CRISP.** We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to CPRCC will be made only with your written authorization. If you do give CPRCC an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and CPRCC will no longer disclose Protected Health Information under the authorization. But disclosure that CPRCC made in reliance on your authorization before you revoked it will not be affected by the revocation.

**YOUR RIGHTS**:

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy**. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records,

other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **Sonia Fischer, HIPAA Compliance Officer**. CPRCC will have up to 30 days to make your Protected Health Information available to you and CPRCC may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. CPRCC may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. CPRCC may deny your request in certain limited circumstances. If CPRCC denies your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. CPRCC will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard CPRCC may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to Amend**. If you feel that Health Information CPRCC has is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to **Sonia Fischer, HIPAA Security Officer**.

**Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures CPRCC made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Sonia Fischer, HIPAA Security Officer**.

**Right to Request Restrictions**. You have the right to request a restriction or limitation on the Health Information CPRCC may use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information CPRCC may disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that CPRCC not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Sonia Fischer, HIPAA Security Officer**.

We are not required to agree to your request unless you are asking CPRCC to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If CPRCC agrees, CPRCC will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and CPRCC will honor that request.

**Right to Request Confidential Communications**. You have the right to request that CPRCC communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Sonia Fischer, HIPAA Security Officer**.

Your request must specify how or where you wish to be contacted. CPRCC will accommodate reasonable requests.

**Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice via the patient portal (at our web site, www.adventistradiation.com.) Front desk staff can provide you with a paper copy of this notice upon your request.

**CHANGES TO THIS NOTICE:**

CPRCC reserves the right to change this notice and make the new notice apply to Health Information CPRCC already has as well as any information CPRCC may receive in the future. CPRCC will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Sonia Fischer, HIPAA Security Officer for CPRCC. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

If you have any questions about this notice, please contact Sonia Fischer, HIPAA Security Officer.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____