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. ❑ Mrs.	❑ Miss ❑ Ms.	Patient's First Name:	Middle:	Last:

Street address:	City:	State	Zip Code:
Mailing address: Same as above	City:	State	Zip Code:

Gender: ❑ M ❑ F	Race (check all that apply) : ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other

Home Phone: ( )	Work Phone: ( )	Mobile Phone: ( )	Home Fax: ( )
Email:	Social Security Number:	Date of Birth:	Preferred Method of Contact: ❑ Phone ❑ US Postal ❑ Email:
Preferred Language:		Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	Marital status (check one) Single Mar Div Sep Widow
Employer:	Employer Address:		Employer phone no.: ( )
Occupation:	Advance Directive and/or Medical Power of Attorney: ❑ Yes ❑ No		

IN CASE OF EMERGENCY

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

PHYSICIAN INFORMATION

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

Previous Radiation Therapy: ❑ 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.)____

____

____

Current Medications

Medication Name	Dose	Frequency	Reason for Taking

Vitamins, Herbal or Nutritional Supplements

Patient Name:___________________________________ **DOB:**_______________

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

BREAST
- ☐Mass I can feel
- ☐Skin changes
- ☐Nipple 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
- ☐Tube Feeding
  ______cans per day
  _________supplement
- ☐Sweats
- ☐Fatigue
- ☐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
- ☐Ear Pain
- ☐Dizziness
- ☐Loss of hearing
- ☐Jaw pain
- ☐Difficulty chewing

EYES
- ☐Blurry vision
- ☐Double vision
- ☐Glaucoma
- ☐Cataracts

GASTROINTESTINAL
- ☐Difficulty swallowing
- ☐Pain when swallowing
- ☐Nausea/vomiting
- ☐Diarrhea/constipation
- ☐Dark, tarry stools
- ☐Reflux

GYNECOLOGIC

Age at first pregnancy _____
Number of pregnancies ______
Live births ___
Age of first menses _____
Age of menopause _____
Hormone use ☐ Y ☐ N
Last Pap smear _________
Last menstrual period _____
Last Mammogram ________
Pregnant ☐ Y ☐ N
Sexually active ☐ Y ☐ N
- ☐Vaginal Discharge
- ☐Vaginal Bleeding

MUSCULOSKELETAL
- ☐Joint or back pain
- ☐Gout
- ☐Arthritis

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

PSYCHIATRIC
- ☐Depression
- ☐Anxiety
- ☐Mood changes

RESPIRATORY

Shortness of breath
- ☐at rest
- ☐with activity

Oxygen? ☐ Y ☐ N
How much?______
- ☐Wheezing
- ☐Cough
- ☐Coughing up blood
- ☐Coughing up phlegm

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

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

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 Management 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 Management/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

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) ____________________
- ☐ Radiation Records ____________________

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)

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

Charlotte Hall
30077 Business Center Drive
Charlotte Hall, Maryland 20622
Phone: 301-884-2508
Fax: 301-884-1704

Medical Record Release Form

Name:_______________________________________ Date of Birth: ___/____/______

I authorize the release of information to: _______________________________________
Name of authorized individual(s)

Health information to be disclosed upon the request of the person named above (check box below):

☐ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

☐ Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):
- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ____

Form of disclosure (unless another format is mutually agreed upon between my provider and designee):
- ☐ Electronic record or access through an online portal
- ☐ Print copy

This authorization shall be effective for all past, present or future times unless specified or revoked:
Other date of expiration: ________________________

NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.

____ ______/_____/_________
Name of person giving this authorization Date

____ ______/_____/_________
Signature of the individual giving this authorization Date

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2013. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office lobby.

What this is all about?

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide a service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the practice manager or doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services.
7. We agree to provide patients with access to their records in accordance with the state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below, I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION AND CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: ___________________________________ **Date:** __________________