Radiation Oncology Centers of nevada

Radiation Oncology Centers of Nevada

Dear Patient:

During a course of radiation treatment, your insurance company will be billed on a regular basis based on the "phase" of therapy you are going through. Treatment courses can be divided into four phases.

PHASE I: THE CONSULTATION

During this phase you will be seen by the radiation oncologist, your records and films (if indicated) are reviewed, and your case is reviewed with other physicians. Sometimes it is necessary to coordinate with others based on the need for additional surgery or chemotherapy, though this is not the case for all patients. After final discussions with you including a review of side effects, possible complications and logistics of radiation, you are ready to move into Phase II.

PHASE II: SIMULATION / PLANNING

In some cases simulation occurs in the actual treatment room (skin cancer). The majority of patients will require a CT simulation, at which time marks and measurements will be obtained. This process is a relatively short amount of time that the patient will need to be in our office. The next step in this process is the planning of the individualized course of treatment. This planning process can take up to 2 weeks to complete. The plans once approved by our physicians will then be turned over to the radiation therapists. You will receive a call from them as to the date and time for you to start your treatments. Multiple charges are billed to your insurance company during this phase of your treatment course. Some of these charges require your presence in the office, but many of the charges are based on work completed by our physics department based on information obtained at the time of the CT simulation. This will all be completed prior to starting Phase III of your treatments.

PHASE III: THE DAILY TREATMENTS

Once the planning is completed, you will return for your regular treatments, usually given once a day, Monday through Friday. Depending upon discussions with your doctor, a course can last from two to nine weeks. The first day usually takes longer because of the initial setup and need to take "verification films" to confirm that what was set up during simulation is reproducible on a daily basis. Your doctor, physicist and therapist will monitor you closely during treatment. The radiation doses, computer plans and other factors are constantly checked and rechecked. Midway through a course of treatment, your doctor may change how the radiation is delivered. This can be done by reducing or changing the size of the radiation area, angling the treatment machine or making additional special blocks. When this is done, additional charges are sent to your insurance company. Once again, most of this planning occurs when you are <u>not</u> in the office. It is possible that the treatment changes can occur two or three times depending on your type of cancer and its location in the body. These changes are to help reduce the risk of damaging the normal tissues around the cancer. Your doctor or a member of our medical staff will see you weekly during therapy, making recommendations or simply keeping you informed of possible side effects developing.

We will gladly manage changes related to radiation including the use of appropriate prescriptions, <u>but</u> we will not "take you away" from your primary doctor, medical oncologist or surgeon, who remains a part of the team managing your medical care.

At the completion of the treatment course, you will be given an appointment to return to see the physician. This is scheduled 2-4 weeks after your last treatment. Make sure you get that scheduled before leaving on the last day of therapy. If for some reason you miss the appointment, you will receive a notice from us instructing you to reschedule your follow-up.

Gregory A. Dean, M.D. • Ritchie N. Stevens, M.D. • Beau James W. Toy, M.D.

624 SOUTH TONOPAH DRIVE, LAS VEGAS, NV 89106 • (702) 463-9100 • 3980 SOUTH EASTERN AVENUE • LAS VEGAS, NV 89119

PHASE IV: FOLLOW-UP

Follow-up appointments are scheduled at regular intervals. If other physicians are involved in your case, a single follow-up only may be given, though in most cases you will be seen in our office periodically for six to twelve months and then perhaps yearly, though many patients are released because of close follow-up in other physicians' office. We will try to coordinate x-rays and blood work through your other doctors; again, it is not our desire to take you away from a doctor-patient relationship that has already been established.

BILLING:

Don't be afraid of billing statements that seem complex. All of the charges are based on the information presented above. Medicare and other insurance companies want each procedure listed separately, hence there can be multiple procedures billed on the same day. We would prefer billing the insurance company a total bill that would simplify life for us as well as you, but this is not possible.

Your insurance company, not us, determines co-payments and coinsurance. Co-payments and coinsurance are due at the time of service. However, for your convenience, we will collect these payments on a weekly basis. For the patients that have a coinsurance, we can only estimate what your responsibility will be. Sometimes it is not possible to bill your secondary insurance for your co-payment or coinsurance. Please be aware, once claims have been sent to your insurance company it can take four to eight weeks for a response. The frustration you feel in this process is the same frustration that we feel. Please note: It is your responsibility to notify the billing department of any changes in you employment status, address and or insurance information. This will help to insure proper filing of claims to your insurance companies.

The Staff of Radiation Oncology Centers of Nevada will do all they can to offer you the best available treatment in a comfortable setting with a minimum of distractions. An explanation of the charges and benefits related to your treatment is available on request once your treatment course is complete.

Wanting only the best for you in a difficult time,

The Doctors and Staff of
Radiation Oncology Centers of Nevada

_____
Patient or Authorized Person

_____
Date

RADIATION ONCOLOGY CENTERS OF NEVADA
NEW PATIENT INFORMATION FORM

Patient Name _____

SSN :____-____-____ Date of Birth: ____/____/____ Age: _____ Sex: ____ Marital Status: _____
Patient Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Work: _____
Employer: _____

Spouse/Parent/Guardian Information

Is Patient a Minor: _____ (If yes, Parent/Guardian Information and Signature Are Required)
Spouse/Parent/Guardian Name:_____
Spouse/Parent/Guardian SSN: ____-____-____ Sex: _____ Date of Birth: ____/____/____
Relationship: _____ Phone: _____
Address: _____ Apt#: _____
Employer: _____ Employer Phone: _____

INSURANCE INFORMATION

We will need your current insurance card(s) and driver's license or photo ID

Primary Insurance:
Insurance Name: _____
Insurance ID#: _____ Group#: _____ Effective Date:_____
Insured's Name: _____ Relationship to Patient: _____
Insured's SSN: ____-____-____ Insured's Date of Birth: ____/____/____ Sex: _____
Insured's Employer: _____

Secondary Insurance:
Insurance Name: _____
Insurance ID#: _____ Group#: _____ Effective Date:_____
Insured's Name: _____ Relationship to Patient: _____
Insured's SSN: ____-____-____ Insured's Date of Birth: ____/____/____ Sex: _____
Insured's Employer: _____

Are you currently enrolled in Hospice or Living in a Care Home? _____Yes _____ No
If yes: Name:_____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Are you receiving benefits from the Veteran's Administration: _____ Yes _____ No

EMERGENCY CONTACT INFORMATION

In case of Emergency other than spouse notify: _____ Phone: _____
Relationship to you: _____
Nearest relative not living with you: _____ Phone: _____
Relationship to you: _____

SIGNATURE

I agree that the above is true to the best of my knowledge. Patient or Parent/Guardian
Signature: _____ Date: _____

RADIATION ONCOLOGY CENTERS OF NEVADA FINANCIAL AND HEALTH INFORMATION POLICY

Dear Patient:

Thank you for allowing us to provide your health care. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign our Financial Policy, as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks and for your convenience MasterCard, Visa and Discover. We will bill your insurance and your secondary insurance when applicable.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Fees for these services and unpaid deductibles are collected at the time of service and co-payment will be due on a weekly basis during treatment.
2. If the insurance carrier does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite payment.
3. Patient responsibility is to be paid in full 45 days after the completion of services.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Radiation Oncology Centers of Nevada (ROCNV). I hereby assign and direct to pay any and all benefits for medical services provided by ROCNV directly to ROCNV. I hereby authorize the release of medical information to process my claim.

I have read and agree to the terms spelled out in the financial policy and benefits assignment. I understand that this assignment applies to all services performed at ROCNV and is in effect until specifically revoked in writing. I further agree that I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Patient's Signature: _____ Date: _____

Health Information Policy

I have received a copy of ROCNV Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that ROCNV may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications.

I understand that ROCNV may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing.

_____

_____

Patient/Parent/Guardian Signature: _____Date: _____

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

Radiation Oncology Centers of nevada

Request for Patient's Health Information

Name: _____ Date of Birth: _____ SSN: _____

Street Address: _____City: _____State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Date of Request:_____

I authorize _____ to release the following information from my medical records.

Description of Records Requested:

_____ History and Physical _____ Progress Notes/Consultations _____ Radiology Reports

_____ Treatment Summary _____ Pathology Reports _____ Lab Results

_____ Other: _____

_____ _____

Signature of Patient or Patient's Representative Date

(If Patient Representative, please provide proof of identity and or describe authority)

New Patient Information Form

Patient Name: _____ Ht:_____ Wt:_____ Temp:_____

Date: _____ BP:____/_____ Pulse:_____

Referring Physician: _____ Date of Birth:_____

Primary Physician: _____

Medical History:

Diabetes…….	Yes	No	Previous Hospitalizations/Surgeries/Serious Injuries	When
Hypertension……..	Yes	No	_____	_____
Cancer……	Yes	No	_____	_____
Stroke…….	Yes	No	_____	_____
Heart Problems…….	Yes	No	_____	_____
Convulsions…….	Yes	No	Medications:	
Bleeding Tendency….	Yes	No	_____	
Acute Infections……..	Yes	No	_____	
Hereditary Defects…..	Yes	No	_____	
Kidney Disease……	Yes	No	_____	
			_____	
			_____	
			_____	

Patient Social History:

Marital Status:	Single___	Married___	Separated___	Divorced___	Widowed___
Alcohol Use	Never___	Rarely____	Moderate___	Daily_____	Previously, quit___
Tobacco Use	Never___	Previously, quit____		Current pack/day_____	
Drug Use	Never___	Type/Frequency_____			
Exposure to Hazardous Materials_____					
Working Status:	Full Time____	Part Time____	Retired____	Not Currently Employed____	Disabled____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____
	___	_____	_____

SYSTEM REVIEW:

- **CONSTITUTOINAL SYMPTOMS**
  - Good general health lately . . . . . NO YES
  - Recent weight change . . . . . NO YES
  - Fever . . . . . NO YES
  - Fatigue . . . . . NO YES
  - Headaches . . . . . NO YES
- **EYES**
  - Eye disease or injury . . . . . NO YES
  - Wear glasses/ contact lens . . . . . NO YES
  - Blurred or double vision . . . . . NO YES
  - Glaucoma . . . . . NO YES
- **EARS/NOSE/MOUTH/THROAT**
  - Hearing loss or ringing . . . . . NO YES
  - Earaches or drainage . . . . . NO YES
  - Chronic sinus problem or rhinitis . . . . . NO YES
  - Nose bleeds . . . . . NO YES
  - Mouth sores . . . . . NO YES
  - Bleeding gums . . . . . NO YES
  - Bad breath or bad taste . . . . . NO YES
  - Sore throat or voice change . . . . . NO YES
  - Swollen glands in neck . . . . . NO YES
- **CARDIOVASCULAR**
  - Heart trouble . . . . . NO YES
  - Chest pain or angina pectoris . . . . . NO YES
  - Palpitation . . . . . NO YES
  - Shortness of breath w/ walking or lying flat NO YES
  - Swelling of feet, ankles or hands . . . . . NO YES
- **RESPIRATORY**
  - Chronic or frequent coughs . . . . . NO YES
  - Spitting up blood . . . . . NO YES
  - Shortness of breath . . . . . NO YES
  - Asthma or wheezing . . . . . NO YES
- **GASTROINTESTINAL**
  - Loss of appetite . . . . . NO YES
  - Change in bowel movements . . . . . NO YES
  - Nausea or vomiting . . . . . NO YES
  - Frequent diarrhea . . . . . NO YES
  - Painful bowel movements or constipation . . NO YES
  - Rectal bleeding or blood in stool . . . . . NO YES
  - Abdominal pain or heartburn . . . . . NO YES
  - Peptic ulcer (stomach or duodenal) . . . . . NO YES
- **GENITOURINARY**
  - Frequent urination . . . . . NO YES
  - Burning or painful urination . . . . . NO YES
  - Blood in urine . . . . . NO YES
  - Change in force or strain when urinating . . . NO YES
  - Incontinence or dribbling . . . . . NO YES
  - Kidney stones . . . . . NO YES
  - Sexual difficulty . . . . . NO YES
  - Male – testicle pain . . . . . NO YES
  - Female – pain with periods . . . . . NO YES
  - Female – irregular periods . . . . . NO YES
  - Female – vaginal discharge . . . . . NO YES
  - Female - # pregnancies ___ #miscarriages _____
  - Female – date of last pap smear _____
- **MUSCULOSKELETAL**
  - Joint pain . . . . . NO YES
  - Joint stiffness or swelling . . . . . NO YES
  - Weakness of muscles or joints . . . . . NO YES
  - Muscle pain or cramps . . . . . NO YES
  - Back pain . . . . . NO YES
  - Cold extremities . . . . . NO YES
  - Difficulty in walking . . . . . NO YES
- **INTEGUMENTARY (skin, breast)**
  - Rash or itching . . . . . NO YES
  - Change in skin color . . . . . NO YES
  - Varicose veins . . . . . NO YES
  - Breast pain . . . . . NO YES
  - Breast lump . . . . . NO YES
  - Breast discharge . . . . . NO YES
- **NEUROLOGICAL**
  - Frequent or recurring headaches . . . . . NO YES
  - Light headed or dizzy . . . . . NO YES
  - Convulsions or seizures . . . . . NO YES
  - Numbness or tingling sensations . . . . . NO YES
  - Tremors . . . . . NO YES
  - Paralysis . . . . . NO YES
  - Stroke . . . . . NO YES
  - Head injury . . . . . NO YES
- **PSYCHIATRIC**
  - Memory loss or confusion . . . . . NO YES
  - Nervousness . . . . . NO YES
  - Depression . . . . . NO YES
  - Insomnia . . . . . NO YES
- **ENDOCRINE**
  - Glandular or hormone problem . . . . . NO YES
  - Thyroid disease . . . . . NO YES
  - Diabetes . . . . . NO YES
  - Excessive thirst or urination . . . . . NO YES
  - Heat or cold intolerance . . . . . NO YES
  - Skin becoming dryer . . . . . NO YES
  - Change in hat or glove size . . . . . NO YES
- **HEMATOLOGIC / LYMPHATIC**
  - Slow to heal after cuts . . . . . NO YES
  - Bleeding or bruising tendency . . . . . NO YES
  - Anemia . . . . . NO YES
  - Phlebitis . . . . . NO YES
  - Past transfusion . . . . . NO YES
  - Enlarged glands . . . . . NO YES
- **ALLERGIC / IMMUNOLOGIC**

  History of skin reaction or other adverse reaction to:
  - Penicillin or other antibiotics . . . . . NO YES
  - Morphine, Demerol, or other narcotics . NO YES
  - Novocaine or other anesthetics . . . . . NO YES
  - Aspirin or other pain remedies . . . . . NO YES
  - Tetanus antitoxin or other serums . . . . . NO YES
  - Iodine, methiolate or other antiseptic . . NO YES
  - Other drugs/ medications . . . . . NO YES

  Known food allergies _____