



## **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 not 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, but 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.

#### **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

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Patient or Authorized Person

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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.



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  
Hypertension..... Yes No  
Cancer..... Yes No  
Stroke..... Yes No  
Heart Problems..... Yes No  
Convulsions..... Yes No  
Bleeding Tendency.... Yes No  
Acute Infections..... Yes No  
Hereditary Defects..... Yes No  
Kidney Disease..... Yes No

Previous Hospitalizations/Surgeries/Serious Injuries      When  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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:**

• **CONSTITUTIONAL 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 \_\_\_\_\_