IRONWOOD CANCER & RESEARCH CENTERS, P.C.

Compassionate Comprehensive Care

Medical Oncology
Parvinderjit S. Khanuja, MD, FACP
Christopher M. Kellogg, MD
Joseph N. Nabong, MD
Puneet Bhalla, MD
Mikhail I. Shtivelband, MD, PhD.
Luke J. Halbur, MD
Michael Musci, MD, PhD
Nathaniel A. Fastenberg, MD
Monique Chang, MD
Sujith R. Kalmadi, MD
Anita Koszyk-Szewczyk, MD
Roopesh K. Kantala, MD
Ian B. DeRoock, MD
Michelle L. Peck ANP- BC
Melissa A. Badahman, FNP-BC
Scott Lightfoot, PA-BC
Katerina Boukouvala, FNP-BC

Radiation Oncology
Charles Woo, MD
Mark K. Ono, MD
S. Eric Olyejar, MD
Aaron A. Ambrad, MD

Elizabeth Mueller, CMPE
Practice Administrator

Jennine Zumbuhl, RN, BSN, MSHA, CCRC
Director of Research

695 S. Dobson Road
Chandler, AZ 85224
(480) 821-2838 phone
(480) 821-9444 fax

6111 East Arbor Avenue
Mesa, AZ 85206
(480) 981-1326 phone
(480) 981-1445 fax

3855 S. Val Vista Drive
Gilbert, AZ 85297
(480) 245-6288 phone
(480) 398-8095 fax

10238 E. Hampton Ave. #504
Mesa, AZ 85209
(480) 981-1326 phone
(480) 981-1445 fax

www.ironwoodcrc.com

Dear Patient:

Welcome to Ironwood Cancer and Research Centers. Please print and complete the following forms prior to your appointment. Bring the completed forms to your first office visit. You will also need to bring your insurance card(s), a picture ID, and a list of your current medications and dosages.

Please arrive 30 minutes prior to your appointment time, for the first visit. Please see the website, www.ironwoodcrc.com, for maps to our specific locations. Please call any of our offices, if you are unsure of which office you are scheduled.

Sincerely,

Ironwood Cancer & Research Centers

Ironwood Cancer & Research Centers
Patient History Form

PATIENT NAME: **DATE:**

Yes	No	N/A		Yes	No	N/A	
			CONSTITUTIONAL				**ENDOCRINE**
			Fever				Thyroid problems
			Fatigue				Diabetes
			Night sweats				Sexual Dysfunction
			Body Weight Loss (lbs)				Painful joints
							Bone pain
			EYES/EARS				Arthritis-type
			Blurred Vision				History of fractures
			Double Vision				
			Floaters				**STOMACH AND INTESTINES**
			Severe Hearing Loss				Chronic abdominal pain
			Ringing in ears				Persistent nausea
			Pain in ears				Heartburn
			Discharge from ears				Appetite loss
							Vomit blood
			NOSE/MOUTH				Skin turn yellow
			Nose bleeds				Black tarry stools
			Nose Congestion				Blood from rectum
			Sores/ulcers in mouth/gums				Clay color stools
			Hoarseness				Constipation
							Hemorrhoids
			NECK				
			Lumps or Masses				**URINARY TRACK**
			Enlarged thyroid				Excessive urination
							Pain or burning
			HEART AND LUNG				Decreased urination
			Chest pain				Cloudy urine
			Heartbeat skips				Blood in urine
			Chronic cough				Night urination (how many times a night?________)
			Spitting up blood				Diminished stream or dribbling
			Ankle swelling				Leakage of urine
			Heart murmurs				Passed any stones
			Difficulty breathing-lying down				Retention of urine
			Difficulty breathing-while walking Distance walked before difficulty				Both kidneys normal function
							FOR WOMEN ONLY
			NEUROLOGICAL				Regular/Irregular
			Fainting				How often?
			Seizures				How long?
			Numbness/tingling				Blood clots
			Trouble with balance				Excessive pain
			Headaches				How many pad/tampons do you use a day?
			SKIN				Number of pregnancies
			Rashes				Number of living children
			Itching				Oral Contraceptives
			Boils				Tubal ligation

Please see other side for additional information needed

Ironwood Cancer & Research Centers
Patient History Form

PATIENT NAME: **DATE:**

What is the primary reason that you are coming to see the doctor?

Past Medical History:

Other physicians involved in your care:

Family History:
Has any one in your family been diagnosed with any of the following?

- ☐ Cancer
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke

Mother living: Yes / No Age at and cause of death:
Father living: Yes / No Age at and cause of death:
Siblings with significant health conditions:

Social History:
Marital Status?
Married Divorced Widowed Single Domestic Partner

Do you drink Alcohol? Yes / No How many drinks a week? _______
Do you smoke? Yes / No Cigarettes___ Pipe___ Cigars____
How long did you smoke? _______
Do you chew tobacco? Yes / No How long? _______
Recreational drug use? Yes / No How long? _______

Occupation:

Are you currently taking any medication? Yes / No

Please list all Prescriptions and vitamins/herbal supplements:

Allergies:

Iodine: Yes / No

Last mammogram date: __________ Last colonscopy: __________ Last DexaScan: ______

Please see other side for additional information needed

Notice of Privacy Practice

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Uses and Disclosures

- *Treatment.* Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- *Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- *Healthcare Operations.* Your health information may be disclosed as necessary to support the day-to-day activities and management of **Ironwood Cancer & Research Centers.** For example, information on the services you received may be used to support the budgeting and financial reporting, and activities to evaluate and promote quality.

- *Law Enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

- *Public Health Reporting.* Your health information may be disclosed to public health agencies as required by state law. For example, we are required to report certain communicable diseases to the state's public health department.

- *Research.* We conduct clinical research here. Our clinical research staff may look at your health records as part of your current care to determine if you may be eligible for any research studies being done at our facility. All patient research conducted at Ironwood Cancer & Research Centers goes through a special process required by law that reviews protections for patients involved in research, including privacy. *We will not use your health information or disclose it outside of Ironwood Cancer & Research Centers for research reasons without getting your prior written approval or determining that your privacy is protected.*

- ***Other uses and disclosures require your authorization***. Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Ironwood Cancer & Research Centers

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice of your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

Complaints/Contact Person

If you would like to submit a question, comment, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Ironwood Cancer & Research Centers
695 S. Dobson Rd.
Chandler, AZ. 85224

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

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Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Ironwood Cancer & Research Centers, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 695 S. Dobson Rd. Chandler, AZ 85224 or 6111 E. Arbor Ave. Mesa, AZ 85206.

With your consent, Ironwood Cancer & Research Centers, P.C. may mail to your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Ironwood Cancer & Research Centers, P.C. may mail to your home or office any items that assist the practice in carrying out any TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound to our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and healthcare operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. **If you decline to sign this consent, we may decline to provide treatment for you.**

Patient Name:

____

Signature of Patient or Legal
Guardian____

Print Legal Guardian Name (If applicable)

____

Date_______________

IRONWOOD CANCER & RESEARCH CENTERS

Consent to Release Health Information

Patient Name: ______________________________ Date: ____________

I hereby authorize Ironwood Cancer & Research Centers to use and disclose my personal health information to the individuals identified on this form. **Initials** ________

I approve and understand that the staff at Ironwood may leave detailed messages on my voicemail. **Initials** ________

Contact Name: ( )

Last *First* *M.I.* *Telephone*

Address:

City *State* *Zip*

☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________ Emergency Contact? ☐ Yes

Contact Name: ( )

Last *First* *M.I.* *Telephone*

Address:

City *State* *Zip*

☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________ Emergency Contact? ☐ Yes

Contact Name: ( )

Last *First* *M.I.* *Telephone*

Address:

City *State* *Zip*

☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________ Emergency Contact? ☐ Yes

1. I hereby authorize Ironwood Cancer & Research Centers to use and disclose my personal health information to the individuals identified on this form.
2. I understand this may include information relating to communicable diseases, such as HIV/AIDS, STD, behavioral, and/or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
3. I understand that the individuals identified on this form will be treated by Ironwood Cancer & Research Centers as individuals involved directly in my care and as such Ironwood Cancer & Research Centers will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Centers.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Cancer & Research Centers will not be affected if I refuse to sign this authorization.

______________________________ ______________________________

Patient Signature Date/Time AM or PM (*circle one*)

______________________________ ______________________________

Personal Representative Signature Relationship Date/Time AM or PM (*circle one*)

Please fill out completely:

Ironwood Cancer & Research Centers

ASSIGNMENT OF BENEFITS / FINANCIAL POLICY

Patient Name:

Last *First* *M.I.* *Home Telephone*

House Address:

City *State* *Zip*

Date of Birth *Age* *Sex* *Social Security Number* *Marital Status*

Employer:

Name Telephone

Are you currently working? Yes or No **Retired? Yes or No** **Disabled? Yes or No**

Responsible Party: Self

Name Relationship Telephone

(Other than patient)

Address State Zip Code

Referring Physician: Primary Care Physician: }

Primary Ins: Telephone:

Insured Name: DOB: Group #: Policy #:

Secondary Ins: Telephone:

Insured Name: DOB: Group #: Policy #:

Tertiary Ins: Telephone:

Insured Name: DOB: Group #: Policy #:

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I, will inform the billing dept of any change in insurance coverage. I understand that I may be responsible for charges if correct insurance is not provided and billed timely. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Ironwood Cancer & Research Centers.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Ironwood Cancer & Research Centers. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.
4. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Ironwood Cancer & Research Centers. I understand that Ironwood Cancer & Research Ctrs will collect any coinsurance amounts that I owe at time of service.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Centers.
6. This assignment will remain valid until revoked by me in writing.
7. I authorize my insurance carrier to release information regarding my coverage to Ironwood Cancer & Research Centers.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Signature/Responsible Party : **Date:**

IRONWOOD CANCER & RESEARCH CENTERS

Please use the form to write down any questions that you may have prior to your visit.

- ______________________________
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