act
Advanced Cancer Therapies

Ellen Cooke, MD
Radiation Oncologist

Joshua Weir, DO, MS, MBA
Radiation Oncologist

LEGACY MEDICAL ARTS
2077 North Webb Road
Wichita, KS 67206

P 316-558-9270
F 316-558-9277

Patient Name:_____ Today's Date: _____ Preferred Language:_____

Date of Birth: _____ Age: _____ SSN: _____ Race: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best contact phone number should we need to reach you about your treatment: _____

Employer: _____ Occupation: _____ ☐ Retired ☐ Disabled ☐ Unemployed

E-Mail: _____ Problem or Diagnosis: _____

Referring Physician: _____ Primary Care Physician: _____

Medical Oncologist: _____ Surgeon: _____

Diagnostic Testing For This Illness: (Please describe when and where completed)

☐ CT Scan(s)	☐ Other Scan(s):
☐ PET Scan(s)	☐ Mammogram(s):
☐ Bone Scan(s)	☐ Ultrasound:
☐ MRI	☐ Surgery:

List All Your Medical Diagnosis: _____

_____

Previous Radiation Therapy? ☐ YES ☐ NO If yes, please list treatment site and location received: _____

_____

Chemotherapy? ☐ YES ☐ NO If yes, please list treatment regimen: _____

_____

Preferred Pharmacy: _____ Phone Number: _____

Family Cancer History:

Relationship	Cancer Type & Site	Age at Diagnosis	Living or Deceased

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Do you live with your spouse? ☐ YES ☐ NO Spouse's Name: _____

Next of Kin: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

CONSTITUTIONAL	GASTROINTESTINAL
☐ Weight Loss or Gain lbs:	☐ Nausea
☐ Loss of Appetite	☐ Vomiting
☐ Fever	☐ Constipation
☐ Weakness	☐ Diarrhea
☐ Fatigue	☐ Bloody Stool
☐ Hot Flashes/Night Sweats	☐ Heartburn/Acid Reflux
☐ Cold or Heat Intolerance	☐ Ulcers/GERD

HEENT (Head, Eyes, Ears, Nose Throat)	GENITOURINARY
☐ Headaches	☐ Urinary frequency
☐ Dizziness	☐ Nocturia
☐ Sinus Problems	☐ Incontinence/Leakage
☐ Blurred or double vision	☐ Burning or painful urination
☐ Hearing Changes	☐ Blood in urine
☐ Mouth Sores	☐ Sexual difficulty
☐ Sore troat or voice changes	☐ Vaginal discharge

CARDIAC	RESPIRATORY
☐ Chest pain	☐ Short of Breath
☐ Pacemaker/Defibrillator	☐ Cough
☐ Palpitations	☐ Wheezing
☐ Irregular heartbeat	☐ Swelling in hands or feet

MUSCULOSKELETAL	PSYCHIATRIC
☐ Muscle weakness	☐ Confusion
☐ Joint pain/Bone pain	☐ Anxiety
☐ Decreased Joint movement	☐ Depression
☐ Bone involvement of disease	☐ Other problems

NEUROLOGIC	HEMATOLOGIC/LYMPHATICS
☐ Numbness/Tingling in extremities	☐ Abnormal bruising/bleeding
☐ Memory loss/Dementia	☐ Swollen glands
☐ Insomnia	☐ Blood Thinners
☐ Seizures	☐ Anemia
☐ CVA/Stroke/TIA	☐ Low blood counts
☐ Balance problems	☐ Other blood/lymph problems

GYNECOLOGIC	SKIN
☐ Pregnant	☐ Rash or sores
☐ Other gynecologic problems	☐ Skin cancer

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Patient Authorization Form

Thank you for choosing Advanced Cancer Therapies as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you please read and sign this form to acknowledge your understanding of our patient financial and insurance policies.

Financial Responsibility – The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of his/her treatment and care. As a patient, I agree to pay Advanced Cancer Therapies any and all charges for services rendered regardless of any assigned insurance benefits. Co-payments, estimated deductibles and coinsurances payments are due, in full, upon completion of your treatment.

Payment Options – I shall submit payment to Advanced Cancer Therapies by cash, check, or credit card. Special financing is available through Care Credit for those who qualify.

Authorization of Care – I grant Advanced Cancer Therapies permission to render care and treatment as my physician deems medically necessary. I understand that such care may include medical and surgical treatment, laboratory tests, diagnostic tests, which may cause me to incur separate charges from other professionals related to these services.

Insurance Assignment – I hereby authorize direct payment of surgical/medical benefits to Advanced Cancer Therapies for services rendered. I understand that I am responsible for charges not covered by my insurance or Third Party Payors. I understand that it is my responsibility to comply with all precertification requirements per my insurance company.

Medicare Assignment of Benefits – I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to Advanced Cancer Therapies and authorize Advanced Cancer Therapies to submit claims to Medicare for payment. I understand that I am responsible for any health insurance deductible and coinsurance.

Authorization for Release of Information – Advanced Cancer Therapies is authorized to disclose necessary information from my medical record to the parties listed below when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third party payor for the purpose of obtaining payment for the services provided. Advanced Cancer Therapies, its employees, officers and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV, and other diseases, all of which I specifically authorize to be so released.

Parties other than patient and patient's physician(s) that are authorized to receive medical information:

_____ Relation to patient _____
(please print)

_____ Relation to patient _____
(please print)

_____ Relation to patient _____
(please print)

Patient Privacy Act – I acknowledge that Advanced Cancer Therapies Notice of Privacy Practices has been offered to me and is available upon request at any time.

I have read, understand, and agree to the provisions of this Patient Authorization Form.

_____ _____ _____
Signature of Patient or Representative Relationship Date

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Billing Information/Assignment of Benefits

Facility:
Advanced Cancer Therapies
2077 N Webb Road
Wichita, KS 67206

Billing Inquiries: (316) 636-6165

Physicians:
Grant P. Rine, MD, Radiation Oncologist, Wichita Radiological Group, (316) 685-1367
Ellen Cooke, MD, Radiation Oncologist, Wichita Radiological Group, (316) 685-1367
Joshua Weir, DO, Radiation Oncologist, Wichita Radiological Group, (316) 68-1367

The staff at this facility appreciates the opportunity to participate in your care. We will do our best to provide the best possible care during your radiation treatment.

Upon completion of treatment, you will receive two statements. One statement from Advanced Cancer Therapies and a second statement from the radiation oncologist's billing office (Wichita Radiological Group/Radiation Oncology Business Solutions). The latter will be the physician's professional fee for planning and directing your treatment.

After your consultation, we will provide the physician's office with most of the information they will need to file your insurance claim. If at any time you have questions or concerns regarding the billing process, please do not hesitate to call and discuss them with the appropriate billing office.

Please assist us in filling your insurance by signing this authorization for assignment of benefits that will be submitted with your claims.

"I authorize the release of any medical information necessary to process this claim and request payment of insurance proceeds, including major medical benefits to doctor and facility checked above.

This will also serve as authorization for their office to obtain insurance information regarding any claims submitted in my behalf." A copy of this signature is valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

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MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED BY ALL MEDICARE PATIENTS)

Patient Name: _____ Account #: _____

1. Is the patient a Veteran? YES NO
   a. Did the VA refer you here for treatment? YES NO
   b. Does the patient have a VA fee basis ID card? YES NO

2. Are services to be paid for by a government program such as a research grant? YES NO
   (If yes, government program pays as primary)

3. Is the patient receiving Black Lung benefits? YES NO

4. Is the medical condition due to an accident of any kind? YES NO
   If yes, was it (circle one)
   a. Work related
   b. Auto
   c. Injured in your own home
   d. Other: _____

5. Is patient covered by a health insurance plan through their own current employment or that of a family member? (not retiree coverage) YES NO

If any answer to questions 1a – 5 is YES – complete other insurance form

6. Is the patient employed? (If no, give retirement date) YES NO DATE: _____

7. Is the spouse employed? (If no, give retirement date) YES NO DATE: _____

8. Complete the following if Medicare eligible due to ESRD (end stage renal disease).
   a. Have you ever received a kidney transplant? YES NO DATE: _____
   b. Have you received maintenance dialysis treatments? YES NO DATE: _____
   c. Self-dialysis program participant? YES NO
      Date training started: _____
   d. Are you within the 30-month coordination period? YES NO
      (If no, Medicare is primary)

Patient Signature: _____ Date: _____

Advanced Cancer Therapies
Notice of Privacy Practices

The notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and disclosures of protected health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

Rights Regarding Electronic Health Information Technology

Advanced Cancer Therapies participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Certain Marketing Activities

We may use your mailing address, email or phone number to communicate with you about products, services and educational programs offered by Advanced Cancer Therapies, to communicate with you about case management and care coordination and to communicate with you about treatment alternatives. We do not sell your health information to any third party for their marketing activities unless you sign an authorization allowing us to do this.

As a patient, you have the following rights:

1. The right to inspect and copy your information (fees may apply)
2. The right to request a restriction of your protected health information
3. The right to request confidential communications
4. The right to request an amendment to your protected health information
5. The right to receive an accounting of certain disclosures
6. The right to receive notice of a breach
7. The right to a paper copy of this notice

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will ensure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is:

Contact Person: Susan Butcher Phone Number: 316-558-9270

Effective Date Of This Notice: November 1, 2014 Revised Date Of This Notice: May 22, 2019