Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

Please allow us to take a moment to welcome you to Southwest Oncology Centers! We are pleased that you have chosen us to be your cancer care providers. It is our responsibility and first priority to deliver the best care possible with a focus on the use of the latest proven technologies combined with our clinical expertise and compassionate care.

Established more than 30 years ago, we are the longest free standing and only independent radiation therapy center in the Valley, with offices also in Minnesota and Mexico. We continually strive to expand our services to better serve you. We provide comprehensive medical oncology services as well as radiation oncology services—IMRT, IGRT, brachytherapy seed implantation, electronic brachytherapy, and intra-operative radiation therapy—and have specialized in the treatment and management of even more difficult problems in terms of locally recurrent and advanced stage cancers. It's this experience that sets Southwest Oncology Centers apart.

Before your first visit, we would encourage you to write down any and all questions you might have; this will serve as a reminder of your concerns during your visit with the doctor. Please also bring as many of your medical records as possible, including operative and pathology reports and imaging studies to avoid duplication of services. If possible, please also write down the names and doses of any medications you currently take. We will also need the following forms filled out prior to your appointment. Our offices are open Monday through Friday from 8:00 am to 5:00 pm.

When you arrive for your first appointment, please bring the following with you:

1. All of your health insurance cards

2. A photo identification

3. A list of physicians who are currently involved in your care. Our physicians automatically update any physicians on this list of your cancer care progress. Please make sure to include each physician's telephone and fax numbers.

We may be contacting you via phone prior to your appointment to obtain a detailed past medical history and other necessary information not included on the enclosed forms.

All co-pays are expected at time of service unless a prior agreement has been made with our staff or billing department.

We understand that appointments sometimes need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

You are welcome to have a friend or family member accompany you to your appointment. We look forward to meeting you (as well as them), and we appreciate the opportunity to participate in your health care.

You have placed yourself in excellent hands.

Sincerely,

The Providers and Staff of Southwest Oncology Centers

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

PATIENT INFORMATION SHEET

Date: _____ (PLEASE PRINT & USE BLACK INK ONLY) Jacket #:_____

Patient's FULL LEGAL Name: _____SSN#_____
Last First Middle

Address: _____ Phone: _____ - _____ - _____
PO Box/Apt or Space # City/Province/State/Zip

Cell: _____ - _____ - _____ Consent to text YES -or- NO Phone: _____ - _____ - _____

E-Mail Address: _____ Birth Date _____/_____/_____ Age: _____ ☐ Male ☐ Female

Employer: _____Occupation: _____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed

RESPONSIBLE PARTY: Name: _____
(NOTE: The responsible party is the person who is ultimately responsible for the medical bill)

Birth Date: _____/_____/_____ SSN# _____ Relationship: _____

Address: _____ Phone: _____ - _____ - _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____ - _____ - _____

***Primary Care Physician: _____ Phone: _____ - _____ - _____**

Address: _____ Fax #: _____ - _____ - _____

***Referring Physician: _____ Phone: _____ - _____ - _____**

Address: _____ Fax #: _____ - _____ - _____

What hospital do you prefer? _____

I understand that by proceeding with services I am responsible for payment of this account. The balance due may include deductibles, office visits, co-payments or other services not paid by insurance or other amounts determined to be patient responsibility. In the event of default, I also understand that collection costs and/or attorney fees may be charged to effect collection. Co-payments are due at time of service. Balances are due at time of billing.

Signature: _____ Date: _____

Southwest Oncology CENTERS

2755 SILVER CREEK RD. SUITE #115 & #127
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222 Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

PATIENT HEALTH QUESTIONNAIRE: page 1 of 2

Name: _____ **Date**: _____

Reason for visit: _____

Current Medications & dosages: _____

_____

List any medications you are allergic to & reaction: _____

_____

Do You Take Blood Thinners, Aspirin Containing Medications, or Non-Steroidal Anti-inflammatory Drugs?

Yes____ No____

MEDICAL HISTORY:

Medical Problems (high blood pressure, thyroid, heart, diabetes): _____

_____

Previous Surgeries – type of surgery and dates: _____

_____

Have you ever had any type of Cancer? If so what kinds and what dates? _____

_____

Previous Chemotherapy (Location, Oncologist, Date): _____

_____

Previous Radiation (Location, Oncologist, Diagnosis, Site Treated, Date): _____

_____

Have you ever received a blood transfusion? If so, when and why? _____

_____

Have you ever had blood clots? If so, when and what part of your body? _____

_____

DO YOU KNOW OF ANY BLOOD RELATIVE with: (indicate relationship)

Cancer or Blood diseases or Genetic Disorders? _____

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

PATIENT HEALTH QUESTIONNAIRE CONTINUED: page 2 of 2

Have you had any of the following problems in the last 3 months or been diagnosed with any of the following?

_____

_____

☐ Loss of appetite	☐ Passing Out	☐ Blood in urine
☐ Severe fatigue	☐ Pneumonia	☐ Arthritis
☐ Shaking/Chills	☐ Bronchitis	☐ Muscle Pain
☐ Fever	☐ Asthma	☐ Stiffness
☐ Night Sweats	☐ Cough	☐ Back Pain
☐ Cataracts	☐ Shortness of Breath	☐ Headaches
☐ Double Vision	☐ Blood in sputum	☐ Dizziness
☐ Glaucoma	☐ Diverticulosis	☐ Loss of balance
☐ Hearing Loss	☐ Heartburn	☐ Weakness of limbs
☐ Ringing in ears	☐ Ulcer	☐ Loss of sensation
☐ Sinus Trouble	☐ Constipation	☐ Numbness
☐ Trouble Swallowing	☐ Loose Stool	☐ Tingling sensation
☐ Sore Throat	☐ Nausea	☐ Memory Loss
☐ Nose Bleeds	☐ Diarrhea	☐ Difficulty Thinking
☐ Heart Problems	☐ Abdominal Pain	☐ Nervousness
☐ Abnormal chest x-ray	☐ Rectal Bleeding	☐ Bone Pain
☐ Stroke	☐ Constipation	☐ Seizure
☐ Light headedness	☐ Weight Loss	☐ Skin Rash
☐ Chest Pain	☐ Frequent urination	☐ Depression
☐ Swelling in legs	☐ Burning on urination	☐ Lumps/Bumps

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

HIPPA COMPLIANCE

NOTICE OF PRIVACY PRACTICES
To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability Act of 1996 (HIPPA).

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Practice Administrator, Southwest Oncology Centers, 2926 N. Civic Center Plaza, Scottsdale, AZ 85251.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Practice Administrator, Southwest Oncology Centers, 2926 N. Civic Center Plaza, Scottsdale, AZ 85251. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Department of Health and Human Resources. To file a complaint with our practice, contact the Practice Administrator, Southwest Oncology Centers, 2926 N. Civic Center Plaza, Scottsdale, AZ 85251. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Practice Administrator, Southwest Oncology Centers, 2926 N. Civic Center Plaza, Scottsdale, AZ 85251.
I hereby acknowledge that I have been presented with a copy of Southwest Oncology Centers' Notice of Privacy Practices.

Signature: _____

Date: _____

Name of Patient: _____

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

AUTHORIZATION FOR THE RELEASE OF INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

I authorize **Southwest Oncology Centers**
- ☐ obtain information from my medical records from:
- ☐ release information from my medical records to:

NAME: _____ PHONE #: (_____) _____-_____

ADDRESS: _____ CITY: _____STATE:_____ZIP:_____

Please provide the following information from my medical records:
- ☐ duplicate copy of my medical records

_____

I hereby consent to the release of records pertaining to treatment/diagnosis of the following:
- o confidential alcohol or drug abuse – related information
- o confidential HIV – related information
- o confidential mental health diagnosis/treatment information
- o confidential communicable disease – related information
- o except as follows: _____

The purpose of this request is for:
- o further medical care
- o insurance
- o radiology (all films are the property of the clinic & must be returned with 30 days)
- o other: _____
- o legal
- o disability/workman's comp

I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below (sixty (60) days for the drug/alcohol treatment records). I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

PATIENT SIGNATURE: _____ **DATE:** _____
or
LEGAL REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

INFORMATION PREPARED & RELEASED BY: _____ **DATE RELEASED:** _____

Southwest Oncology CENTERS
2755 SILVER CREEK RD. SUITE #115
BULLHEAD CITY, AZ 86442
Ph:(928) 514-2222
Fax:(928) 514-2221

GORDON L GRADO, MD, FACRO, FACR, Medical Director
VALERIE ISRAEL, D.O
ROBERT O' LAUGHLIN, MD

MEDICATION HISTORY RETRIEVAL

We have a great tool that will allow us to electronically obtain your medication history to ensure that our records are complete. We use Sure Scripts to provide medication histories when your medication is obtained from most major pharmacies. However, in order to obtain this information, we need your approval. Please check yes that you would like us to obtain that information.

- ☐ **Yes, please obtain my medication history.**
- ☐ **No, you may not obtain my medication history.**

_____ _____

Patient Signature **Date**

_____

Print Patient Name

In addition, we can send your prescription needs to your pharmacy electronically. However, to be able to do this we require the name and location of your pharmacy.

_____

Pharmacy Name

_____

_____

Address, City, State Zip

_____

Pharmacy Telephone Number