NORTH CENTRAL REGIONAL CANCER CENTER
1401 River Road
Greenwood, MS 38930

PATIENT INFORMATION

Patient Name: _____ Date: _____

Home Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SSN: _____

Sex: M _____ F _____ Height: ___ft. __in. Current Weight: _____

Employer: _____ Phone #: _____

May we contact you at work? Yes: _____ No: _____

Marital Status: (circle one): M, S, D, or W: Spouse's Name: _____

Referring Physician: _____ City: _____ State: _____

Family Physician: _____ City: _____ State: _____

Are you on Hospice: Yes: _____ No: _____

Person to contact in Case of Emergency: _____

Relationship to Patient: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Supplemental Insurance: _____ Policy #: _____

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits under and insurance policy(es) or other settlement, if any, to North Central MS Regional Cancer Center for any Medical Services. I understand any copays or charges in excess of the amounts paid by my insurance policy(ies) are my responsibility. It is also my responsibility to determine whether your services are covered by insurance policy(ies). A copy of this authorization shall be considered as valid as the original.

_____
Patient or Responsible Party

Consent for Treatment

I have come to the LeFlore Cancer Treatment Center for the purpose of diagnosis and treatment of the following medical conditions:

I have been informed by Dr. Arnold Smith, M.D., that the Cancer Center utilizes a variety of modalities and approaches for providing care for this and similar conditions, including but not limited to radiation therapy, chemotherapy medications, nutrient therapy, and similar modes.

I understand that some of the modalities employed by the Cancer Center are not approved by either the federal Food and Drug Administration or any other agency of the state or federal governments for the uses for which the medications will be employed. Specifically, I have been informed that the Cancer Center utilizes medications "off label" which means that they are prescribed by the Cancer Center for purposes other than for which they have been approved by the FDA, This specifically includes the medication Ukraine.

I further understand that these medications are recommended by Dr. Smith based upon his own experience and that of his colleagues in treating the type of condition from which I suffer but specifically not based upon the extensive testing and study usually associated with FDA approval. For this reason, the safety and usefulness (efficacy) of these medications HAS NOT BEEN ESTABLISHED to the extent required by federal law. In that sense, the uses for which the Cancer Center intends to employ these medications to treat me could be considered unproven or experimental. In some instances, the uses proposed by the Cancer Center may not be accepted by a majority of medical oncologists throughout the country. In some instances as well, further research and testing could reveal that these medications are not useful for treating the condition from which I suffer or have unknown side effects, which could be serious.

While I have been informed by the Cancer Center that these medications have shown themselves to be useful in treating the type of condition from which I suffer, despite lack of governmental approval, nonetheless, I understand that there can be no assurance that, if I allow the Cancer Center to administer these medications to me, my condition will improve or that my cancer will go into remission. Neither Dr. Smith nor any other person from the Cancer Center has provided me any assurance or guarantee of a favorable outcome from the treatment that he or it may recommend for me. To the contrary, he and the Cancer Center have informed me that the conditions from which I suffer are very difficult to treat using any modality and that there is a significant chance that no treatment may be efficacious in treating my condition, whether the treatment be approved by the FDA or otherwise. Neither Dr. Smith nor the Cancer Center has made any assurance whatsoever to me except to say that, in their experience, the medications which they propose I utilize have helped others in the past.

I further understand that, by agreeing to undergo the therapies recommended by the Cancer Center, I may forego other more conventional forms of therapy which could also assist in treating my condition.

Considering this Information, I have elected to follow the recommendations for treatment provided to me by Dr. Smith and the Cancer Center, assuming any risk resulting from the lack of FDA approval for the uses to which they intend to employ these medications. I have consented to do so with an understanding of the potential risks and the possibility that these medications will not benefit me. I have also consented with the knowledge that the risks of taking these medications may include death or serious physical impairment I have been given the opportunity to ask any questions about this proposed treatment and any questions I have raised have been answered fully and to my complete satisfaction.

_____

[Patient]

_____

[Witness]

Date: _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance however you are responsible for your co pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 45 days you are responsible for the balance due. It is also the patient's responsibility to obtain referral from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for the payment in full on the day of service, if we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release any Information acquired in the course of my treatment to my insurance company as need to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

_____

Witness

I request that payment of authorized medigap (Medicare supplement) benefits be made on my behalf to the provider for any services furnished me by that provider. I authorize any holder of medical information about me; to release to medigap Insurer _____ any information needed to determine these benefits payable for related services.

_____ _____

Signature Date

Medicare Lifetime Authorization

HIC# _____

Medicare Certification far Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct I authorize any holder of medical information about me to release to the Social Security Administration or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf, I assign the benefits payable for physician services to the physician or organization that furnished the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed: _____ Date: _____

Print Name: _____ Title or Relationship: _____

Witnessed by: _____ Address: _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

_____

North Central Mississippi Regional Cancer Center, Inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, North Central Mississippi Regional Cancer Center, Inc. may use and diagnose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to North Central Mississippi Regional Cancer Center, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. North Central Mississippi Regional Cancer Center, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request North Central Mississippi Regional Cancer Center, Inc.'s Privacy Officer at P.O. Box 549, Greenwood, MS 38930, Vicksburg, MS 39180. With my consent, North Central Mississippi Regional Cancer Center, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent North Central Mississippi Regional Cancer Center, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statement as long as they are marked Personal and Confidential.

With my consent, North Central Mississippi Regional Cancer Center, Inc. may e-mail to my home or other designated location any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements. I have the right to request that North Central Mississippi Regional Cancer Center, Inc. restrict how it uses or discloses my PHI to carry out TOP.

However, the practice is not required to agree to my required restrictions, but if it does, it is bound by agreement.

By signing this form, I am consenting to North Central Mississippi Regional Cancer Center, Inc.'s use and disclosure of my PHI to carry out TOP. I may revoke my consent in writing except to the extern that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, North Central Mississippi Regional Cancer Center, Inc. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

North Central MS Regional Cancer Center
Information Request
Patient Authorization for Release

I, _____, hereby authorize the release of my information to this person, _____.

Date: _____

Signature: _____

Print Name: _____

Witness: _____

Doctor's signature: _____

NORTH CENTRAL MISSISSIPPI
REGIONAL CANCER CENTER
Patient Authorization for Release of Medical Information

Patient Name_____

Date of Birth _____

Social Security Number_____

This patient has been referred to NCMRCC for treatment. Please fax copies of the items indicated below to 662-459-7136 at your earliest convenience. We sincerely appreciate your efforts. Thank you.

___History and Physical	**___Progress Notes**
___Radiation Treatment Summary	**___Demographics**
___Operative Reports	**___Pathology Reports**
___Imaging (CT, PET, MRI, X-Ray)	**___General Labs (CBC)**
___Markers (CA125, CEA, PSA, etc)	**___Consultation Reports**
___Discharge Summary	**___Chemo Flow Sheets**

I hereby authorize the release of all medical information as requested above. This authorization expires one year from the date below.

_____ _____

Signature **Date**

PATIENT INITIAL HISTORY QUESTIONAIRE (HANDOUT)

Name: Street: City:	Preferred Nickname:			
	Phone			
	Day Phone		Age	

I have seen the following specialists ☐ Radiation One ☐ Medical One ☐ Surgical One Other: _____

Who will accompany you on your first visit _____ Relationship _____

Can a family member be included? ☐ no ☐ yes If yes, relationship and name _____

Chief complaint: Explain the reason you are here today. _____

_____

PAST MEDICAL HISTORY (Have you ever had any of the following?)

	Date	Explain
Prior Radiation		
Prior Cancers		
Prior Chemotherapy		

PAST MEDICAL HISTORY (Have you ever had any of the following?)

Anemia		Heart Attack		Pancreatitis	
Angina		Heart Failure		Parkinson's Disease	
Arthritis		Heart Murmur		Psychiatric Treatment	
Asthma		Hemorrhoids		Rheumatoid Arthritis	
Blood Clots		Hepatic or Liver Disease		Seleroderma	
Chronic Bronchitis/Emphysema		Hiatal Hernia		Seizures or Epilepsy	
Colitis		High Blood Pressure		Severe Anxiety	
Crolm's Disease		Human Immune Virus		Skin Condition(s)	
Cystitis or Bladder Infections		Irregular Heartbeat		Stroke or Paralysis	
Depression		Kidney Failure		Thyroid disease or Goiter	
Diabetes or Sugar		Kidney Stones		Tuberculosis	
Diverticular Disease/Polyps		Lupus		Ulcers of Stomach or Duodenum	
Gallbladder Disease		Multiple Sclerosis			
GYN Problems/Infections		Other Collagen Vascular Disease			

Other illnesses or medical problems

DO YOU HAVE?	Yes	No		Yes	No
Dentures?			Hearing Aid?		
Glasses/Contacts?			Pacemaker?		
Artificial Joints?			Where?		
Prosthesis?			Type?		
Special Diet?			Describe:		

Do you have a Living Will? ☐ yes ☐ no	If no, do you want information? ☐ yes ☐ no

List all surgeries and approximate year:

OPERATION	YEAR	FACILITY PERFORMED

List all trauma and/or fractures and approximate year:

TRAUMA/FRACTURE	YEAR	TRAUMA/FRACTURE	YEAR

List all medications you are currently taking (prescribed and home remedies) and bring all medicines with you.

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY

List any allergies you have to food or medicine:

FOOD AND/OR MEDICINE	REACTION

List any alternative health treatments you use:

	Yes	No	Prayer	Yes	No
	Yes	No	Other	Yes	No

List any other alternative medicines:

SOCIAL HISTORY: (Please check all that apply.)

Education:

☐ Completed Grammar School ☐ Completed High School ☐ Completed College Other _____

Language:

Is English your primary language? ☐ yes ☐ no If no, list primary language_____

Marital Status

☐ Married ☐ Widow(ed) ☐ Separated ☐ Single ☐ Divorced

Spouse's Name: _____

Living Arrangements

☐ Independent ☐ Assisted Living ☐ Social Work Visits
☐ Live Alone ☐ Nursing Home ☐ Visiting Nurse
☐ Live with other(s) ☐ Meals on Wheels

What floor do you live on? _____

Do you feel your environment at home is safe? ☐ Yes ☐ No Explain: _____

Has your illness forced a change in usual living situation? ☐ Yes ☐ No Describe: _____

Have you been forced to move due to your illness? ☐ Yes ☐ No Describe: _____

No. living in house _____ Relationship _____

Principle Care Person _____ Does Person Live with Patient? _____ Relationship to Pt.____

Health of Principle Care Person: _____ Willing/Able to Help? ☐ Yes ☐ No

# of Children _____

List Child's Name	Age	City and State (Permanent Address)

EMPLOYMENT AND OCCUPATION HISTORY

Occupation _____ Are you still working? ☐ Yes ☐ No

Were you exposed to carcinogenic substances, asbestos? ☐ Yes ☐ No List: _____

Has your illness forced you to stop working? ☐ Yes ☐ No Date: _____

Has your illness forced significant other to stop working? ☐ Yes ☐ No Date: _____

Has your illness forced significant other to change hours? ☐ Yes ☐ No Date _____

List your present and past jobs and a brief description of your duties:

_____

_____

USE OF TOBACCO, ALCOHOL AND/OR DRUGS:

Do you use tobacco? ☐ Yes ☐ No			Did you ever use tobacco? ☐ Yes ☐ No		
If yes, circle type of products	cigarettes	pipes	snuff	chew	Cigars
What age did you start?	How much?		Date Stopped		
Do you use Alcohol? ☐ Yes ☐ No			Did you ever use Alcohol? ☐ Yes ☐ No		
If yes type of products					
What age did you start?	How much?		Date Stopped		
Do you use any illicit drugs? ☐ Yes ☐ No			Did you ever use drugs? ☐ Yes ☐ No		
If yes type of products					
What age did you start?	How much?		Date Stopped		

FAMILY HISTORY

Mother: ☐ Alive ☐ Dead Cause of Death? Age _____

Father: ☐ Alive ☐ Dead Cause of Death? Age _____

Family History of Cancer:

			Type/cause death				Type/cause death
Mother	yes ☐	no ☐		Father	yes ☐	no ☐	
M. Grandmother	yes ☐	no ☐		M. Grandmother	yes ☐	no ☐	
M. Grandfather	yes ☐	no ☐		M. Grandfather	yes ☐	no ☐	
Sister(s)	yes ☐	no ☐		Aunt(s)	yes ☐	no ☐	
Brother(s)	yes ☐	no ☐		Uncle(s)	yes ☐	no ☐	

Please list the family member and check the appropriate box if there is a history of the following disease(s):

☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Diabetes

☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Diabetes

List other hereditary diseases: _____

SOCIO-ECONOMIC

Church Affiliation (optional): _____

Transportation Problems: _____

Care Needs: _____

Any financial concerns staff can help with? _____

History of abuse that may affect your treatment that you would like us to know about? ☐ Yes ☐ No

Describe: _____