

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.

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[Patient]

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[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 extent 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.

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Signature of Patient or Legal Guardian

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Patient's Name

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Date

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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 QUESTIONNAIRE (HANDOUT)				
Name:	Preferred Nickname:			
Street:	Phone			
City:	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	Scleroderma
Chronic Bronchitis/Emphysema	Hiatal Hernia	Seizures or Epilepsy
Colitis	High Blood Pressure	Severe Anxiety
Crohn'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	DO YOU HAVE?	Yes	No
Dentures?			Hearing Aid?		
Glasses/Contacts?			Pacemaker?		
Artificial Joints?			Where?		
Prosthesis?			Type?		
Special Diet?			Describe:		



**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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you ever use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you ever use Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes type of products					
What age did you start?		How much?		Date Stopped	
Do you use any illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you ever use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

	yes <input type="checkbox"/>	no <input type="checkbox"/>	Type/cause death	yes <input type="checkbox"/>	no <input type="checkbox"/>	Type/cause death
Mother	<input type="checkbox"/>	<input type="checkbox"/>		Father	<input type="checkbox"/>	<input type="checkbox"/>
M. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>		M. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>
M. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>		M. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>		Aunt(s)	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>		Uncle(s)	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

