Tammy Walker Cancer Center
Salina Regional Health Center

Jeffrey M. Geitz, M.D.
Larry K. Beck, M.D.

Muhammad S. Ahmed, M.D.
Peeran D. Sandhu, M.D.

Name: _____

Address: _____
_____

Welcome to Tammy Walker Cancer Center/Hematology-Oncology Dept.,

In order to make your visit as pleasant as possible, please fill out the enclosed information and bring with you for your appointment scheduled with _____ on _____, _____ **at** _____.
Please *check-in 30 minutes before* your appointment time.

Remember to bring all current medical, prescription, and driver's license cards.*
If you have a Living Will and Durable Power Attorney we would like a copy.

* If your insurance requires a referral please contact your primary doctor and have them forward that to our office by mail or fax: (785) 452-4878.
* Any questions regarding the Hereditary Cancer Questionnaire please call (785) 452-7038.
* For insurance and billing questions for Tammy Walker Cancer Center Oncology/Hematology Dept. you may call the Financial Counselor at (785) 452-4873.
* Many of your tests/procedures will be provided by and/or billed through Salina Regional Health Center . If you have questions or would like to be screened for financial assistance, please call (785) 452-6299 to speak to a customer service representative.

To cancel or reschedule appointment please call us 24 hours prior to your appointment. We will be happy to reschedule your appointment.

If you have any questions, please feel free to call us at (785) 452-4860.

We look forward to seeing you.

511 S. Santa Fe Salina, KS 67401
Ph: (785) 452-4860 Fax: (785) 452-4878

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Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

REGISTRATION FORM

PATIENT INFORMATION
Date: _____

Patient Name: _____ Age: ____ Sex: ____
First MI Last

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ SSN: _____

(circle): Single Married Widowed Divorced Other: _____

Referring Physician: _____ Primary Physician: _____

EMPLOYMENT
(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled Minor

If Disabled, are you disabled due to your current pain? Yes No

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (Ext: _____)

PERSON RESPONSIBLE FOR BILL
(circle): Same as Patient Parent/Guardian Other: _____
(if other than patient please fill in the following information)

Name: _____ SSN: _____
DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Ext: _____

Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

****Is this visit due to an Accident? YES or NO****
If so what type of accident? WORKERS COMPENSATION - MOTOR VEHICLE ACCIDENT
OTHER-EXPLAIN_____
Date of Injury:_____
Claim#_____
Contact Name:_____Contact Phone#_____
Insurance Carrier:_____
Address:_____

INSURANCE
Primary Insurance: _____

Policy Holder: (circle): Same as Patient Spouse Parent/Guardian Other: _____
(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

DOB of insured: _____ SSN of insured: _____ Sex of insured: _____

(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: _____(Ext: _____)

Secondary Insurance: _____
Policy Holder: (circle): Same as Patient Spouse Parent/Guardian Other: _____
(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

DOB of insured: _____ SSN of insured: _____ Sex of insured: _____

(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____(Ext: _____)

WE CANNOT FILE INSURANCE WITHOUT A COPY OF YOUR INSURANCE CARDS FOR VERIFICATION OF COVERAGE
(see next page for signature).

Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

EMERGENCY INFORMATION

Person to notify: _____ Phone number: _____

Relationship to patient: _____

(circle): Address is same as patient Different address (please fill in the following information)

Address: _____

City: _____ State: _____ Zip: _____

Next of kin or friend: _____

Relationship to patient: _____ Phone number: _____

Address: _____ City _____ State: _____ Zip: _____

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my provider for this illness or injury, of the provider's benefits otherwise payable to me, but not to exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the provider's office or the party responsible for the billing of these services may check credit with any source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

I have been notified that I may receive services from the Nurse Practitioner or Physician Assistant at this location.

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

_____ Date: _____
Patient or Authorized Person's Signature

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Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

Salina Regional Health Center Contact List /Authorization to Verbally Release Protected Health Information Contact List:

I authorize Salina Regional Health Center health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, caretakers, concerning my health care will not be disclosed without an additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Name of Family Member/Caretaker	Relationship	Phone Number	Allow Messages
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

I was transferred (referred) to Salina Regional Health Center from _____ facility. Should this facility contact SRHC, I authorize SRHC to update the referral facility on my condition. (If left blank, will default to not authorized and SRHC will not update referral facility).

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be-disclosed and no longer protected by those regulations.

X_____ X_____
Date Signature of Patient or Authorized Agent/Representative

_____ _____
Printed name of authorized agent/representative Relationship to patient

_____ _____
Address of Authorized agent/representative Telephone # of authorized agent/representative

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")

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TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT

Salina Regional Health Center Physician Clinics, including its acute care rehabilitation unit, emergency departments, outpatient surgery and outpatient departments are herein referred to as "medical group".

1. CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. Further, I understand that among those who attend patients at this medical group are medical, nursing, and other health care personnel in training and volunteer student observers who, unless requested otherwise, may be present during patient care as a part of their education. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by me or my family and the medical group shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the medical group determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

3. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS: I agree that the medical group may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

4. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as a patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the medical group in accordance with its regular rates and terms.

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the medical group. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable cost of collection, including but not limited to attorney fees and collection agency fees.

6. MEDICARE/MEDICAID/INSURANCE BENEFITS: I authorize the medical group to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the medical group for services furnished me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital.

Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

7. AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES AND WAIVER OF ACCOUNTING: I understand that as part of its health care operations, the medical group is required by law to disclose certain of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize the hospital to make such disclosures without any accounting of such disclosures since they are required by law.

8. CONTRABAND WEAPONS/DRUGS: I agree that should the medical group find contraband weapons and/or nonprescription drugs not sold over-the-counter with my possession, these items will be confiscated and the police will be contacted.

9. TOBACCO PRODUCTS: Salina Regional Health Center is a tobacco free campus. Tobacco use is prohibited on all hospital owned properties including outdoor areas, stairways, parking lots and garages, medical office building properties and entryways. Please send your smoking materials home. If you do smoke, please consider asking your nurse regarding information on smoking cessation programs.

10. PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

11. PATIENT RIGHTS INFORMATION: I have reviewed/received "Patient Right and Responsibilities" and understand my rights as described in that document.

12. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the work place may be disclosed to your employer.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

X_____
Patient/Personal Representative Initial

13. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that I have received
a copy of the medical group's Notice of Privacy Practices.

X_____
Patient/Personal Representative Initial

I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

x_____ _____ _____
Patient/Personal Representative Signature Relationship to Patient Date

x_____ _____
Signature, Witness Date

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Date: **Patient name:** **DOB:**

Preferred Method of Contact - Please select preferred method and complete. (ONLY MARK ONE)

( ) Cell Phone: _____ *Allow Messages:* **Yes or No**

( ) Email: _____

( ) Home Address: _____

( ) Home Phone: _____ *Allow Messages:* **Yes or No**

( ) Work Phone: _____

Would you like invited to our PATIENT PORTAL (My Care Plus)? Please complete below:

Yes: _____ My email address is: _____

No: _____ I am not interested in the patient portal

Preferred Language (ONLY MARK ONE)

( ) English

( ) French

( ) Italian

( ) Japanese

( ) Portuguese

( ) Russian

( ) Spanish

Please return to the Front Desk. THANK YOU!

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Medicare Secondary Payer Questionnaire
(To be completed for All Medicare Patients)

Patient Name: _____ **Date of Birth:** _____

Payer Questions

1. Are you receiving Black Lung Benefits?
   Yes No

2. Are the services to be paid by a government program such as a Research Grant?
   Yes No

3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   Yes No

4. Is this medical condition due to an accident of any kind?
   Yes No
   If Yes was the injury:
   Work related _____
   Auto related _____
   Injury in your home _____
   Other _____ Please explain: _____

5. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member?
   Yes No

6. Are you entitled to Medicare based on:

Age:	Yes	No
Disability:	Yes	No
ESRD: (end stage renal disease)	Yes	No

Date: _____

Patient's Initials: _____

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Date: _____
Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: _____

MEDICATION LIST

Medication Name	Dose	How often are you taking?	What is the medicine for?	Reviewed Date

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HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** ______________

Gender (M/F): ________ **Today's Date(MM/DD/YY):** ____________ **Healthcare Provider:** ________________

Reason for Today's Visit: ____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-----	—	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: ________________________________ Date: ______________

Healthcare Provider's Signature: ________________________________ Date: ______________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: __________

RESOURCE SUPPLIED BY MYRIAD GENETIC LABORATORIES, INC.

MYRIAD myRisk™ Hereditary Cancer