Memorial Cancer Center

Welcome to the Cancer Center – Radiation Oncology:

As with anything new, we want to make sure that you are aware of clinic rules. These rules help us take care of you and all the other patients we serve.

If you have any questions, we would be happy to answer them.

- Children under the age of 12 are not permitted in the Cancer Center.
- The Radiation Oncology office is a SCENT FREE ZONE. Please avoid wearing anything that has a fragrance. Smells can cause patients to have nausea.
- All prescriptions require a 72 hour turn-around time. Please plan accordingly.
- We are not a walk-in clinic, therefore, appointments are required.
- The physicians in this clinic do not complete medical cannabis paperwork.
- This clinic and the hospital (as well as the grounds) are completely smoke free. If you have a strong smell of tobacco or marijuana, you may not been seen.
- No weapons are permitted.
- ALL paperwork requires FIVE working days to complete before pick up.
- You must keep your appointments and notify the office if you need to reschedule. More than two missed appointments, without notice, may lead to termination as a patient in this clinic.
- Nurses are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. You will receive a call back (almost always) the same day. Please only call once. If you feel it is an emergency, please notify us that you are going to the Emergency Room.
- If you are admitted to the hospital, please let the hospital physician know to call us.
- If you arrive more than 15 minutes late for your appointment, you may be rescheduled.
- Arriving too early for your appointment does not mean you will be seen any sooner than your scheduled appointment time.
- Patients on oxygen are asked to bring their own tank, allowing enough oxygen for approximately 2 hours. Your oxygen carrier may also deliver to our office.
- Please notify the Front Desk of any change in insurance, address or phone numbers.
- All VA and/or Triwest patients: Please verify that you have a current authorization.
- Please minimize cell phone use when seeing the Physician.

Sincerely,

Lisa Martinez

Elizabeth (Lisa) Martinez
Radiation Oncology Office Manager
Clinic Phone Number: 575-556-5800

Lynn Fletcher, RN, BSN, MBA, CPPS
Director of the Cancer Program
Clinic Phone Number: 575-521-1554

Commission on Cancer® ACCREDITED PROGRAM

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Notice of **Privacy Practices**

EFFECTIVE DATE – June 1, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to **Memorial Medical Center** and the doctors and other healthcare providers practicing at this facility. This notice also applies to **Las Cruces Physician Practices (DBA: Memorial Physician Practices)**

It is our legal duty to protect the privacy and security of your information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We are providing this notice so that we can explain our privacy practices. We must follow the duties and privacy practices described in this notice or the current notice in effect. For more information about our privacy practices, to place a complaint or report a concern or conflict, call the number listed below:
Memorial Medical Center Privacy Officer: Sheena Albright
Phone: 575-532-7435 Email: Sheena.Albright@LPNT.net

Or, if you prefer to remain anonymous, you may call the toll-free number listed below and an attendant will handle your concern anonymously.
1-877-508- LIFE (5433)

You also may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate address or visit **http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.** Under no circumstance will you be retaliated against for filing a complaint. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. We may use your information in treatment situations if we need to send or share your medical record information with professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition. We can use and share your health information to bill and receive payment from health plans or other entities. We will give your information to your health insurance plan such as Medicare, Medicaid or other health insurance plans so it will pay for your services. Your information will be used when processing your medical records for completeness and to compare patient data as part of our efforts to continually improve our treatment methods. We may disclose your information to business associates with whom we contract to provide service on your behalf that require the use of your health information. We can use and share your health information to run our practice, improve your care and contact you when necessary. We may contact you or disclose certain parts of your health information to our associates or related foundations for fundraising purposes. You have the right to opt out of receiving such fundraising communications. We may share certain information with a person(s) you identify as a family member, relative, friend or other person that is directly involved in your care or payment for your care, or to your "Lay Caregiver" or appointed Personal Representative if you tell us who these individuals are. If it becomes necessary, we will notify these individuals about your location, general condition or death. **We maintain a hospital directory listing the patients currently receiving care in our facility.** In addition, we may need to disclose medical information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example if you are unconscious, we may also share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information unless you give us written permission in these cases: for marketing purposes or the sale of your information.

Under certain circumstances, we may be required to disclose your health information without your specific authorization. Examples of these disclosures are: requirements by state and federal laws to report cases of abuse, neglect, or other reasons requiring law enforcement; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests and to prevent serious threats to health or public safety such as preventing disease, helping with product recalls, and reporting adverse reactions to medications. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health-related services that may be of benefit to you. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request unless we may have already acted.

As a patient, you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. This may take up to 30 days to prepare, and there may be a preparation fee associated with making any copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations that you have not specifically authorized but that we are required to do by law (see section on how your information may be used and disclosed). We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct your paper or electronic medical records. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can also request that your health information be communicated to you at an alternate location or address that is different from the one we received when you were registered. If you pay for your service in full up front, you can ask that we not disclose information about your treatment to your health plan. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice except to persons involved in your care, or when required by law or in emergency situations. We are not legally required to accept such a request, but we will try to honor any reasonable requests.

Lastly, a note about Patient Portals and health information exchanges (HIE):
Patient Portal: The Patient Portal is a mechanism by which you, or your authorized representative, can access your health information online after your care and treatment. Such information will include, but is not limited to, procedures that were performed, a list of current or past medical issues, discharge instructions, medical history, and lab results. Patients, or their authorized representatives, are only provided access to their own health information, and no other individual may access such a patient's health information via the Patient Portal. If you do not want your medical information to be placed in the patient portal, you can opt out by submitting the opt out form. It will take five business days for the opt out to go into effect.
Health Information Exchange: We may use or share your health information as part of our participation in a Health Information Exchange or Network. These are organizations with other healthcare providers, insurers, and/or health care industry participants and their subcontractors. We may share your health information with a Health Information Exchange or Network and its participants to accomplish goals that may include but not limited to: Providing you with treatment; billing for services provided to you; running their or our organization; complying with the law; and such purposes as may be permitted by law and the agreements and rules governing the Health Information Exchange or Network. Pursuant to the New Mexico Health and Safety Statute Chapter 24, Article 14A , you will be provided with a Notice of Health Information Practices with respect to each Health Information Exchange in which we participate. The Notice of Health Information Practices is separate and apart from this Notice of Privacy Practices document, and is managed by the administrator of each such Health Information Exchange. You will be asked to acknowledge your receipt of the Notice of Health Information Practices with your signature. Currently, this facility/practice participates in the following Health Information Exchanges:

1. New Mexico Health Information Exchange
    a. Administrator: Dr. Thomas East
    b. Participants: Hospitals and healthcare providers that are licensed to practice in the state of West Virginia

Patient Rights and Responsibilities

While you are a patient at Memorial Medical Center, you are our partner in your medical care. We want you to have the information you need to help us provide you with the best care. MMC respects your personal decisions and choices, and values you as an individual.

Your Rights as a Patient:

Access
You have the right to the best available care that is medically necessary, regardless of age, race, beliefs, gender, sexual orientation, national origin, disability, or sources of payment for care.

Respect and Dignity
You have the right to care that is considerate and respectful of your personal values and beliefs and to have access to pastoral/spiritual care. The right to your personal dignity is respected.

Informing Family/Physicians
You have the right to have the hospital notify your family and your own physician with your permission.

Information
You have the right to complete information about your condition, treatment, likely outcomes and unanticipated outcomes, in terms you can understand and to discuss this information with your physician. Interpreter services and communication aids can be provided if needed.

Plan of Care
You have the right to be involved in making decisions about treatments during your hospital stay and to be involved in your plan of care. You have the right to the appropriate assessment and management of your pain. You have the right to request, at your own expense, a second opinion or to see a medical specialist.

Medical Records
You have the right to review, amend or obtain copies of your medical records and to have the information explained in a reasonable time frame, except when restricted by law.

Identity
You have the right to know the names and roles of the people responsible for your care, as well as those treating you.

Consent
You or the person you choose, have the right to consent to or refuse a treatment, as permitted by law, throughout your MMC stay. You have the right to receive information needed to consent or refuse in terms you understand.

Advance Directives
You have the right to have an advance directive, to appoint someone to make healthcare decisions for you or to write your End of Life decisions. You have the right to review and revise your advance directives at any time. You have the right to know that healthcare providers will follow your directives to the extent permitted by law and hospital policy.

Confidentiality
You have the right to expect that information about your MMC stay will be kept private, unless you give permission to release information or reporting is required or allowed by law.

Continuity of Care
You have the right to expect that MMC will give health services to the best of its ability. You have the right to be told of care alternatives when MMC is no longer the appropriate level of care. Referral or transfer for additional services may be recommended. You have the right to be informed of any continuing health care requirements following your discharge from the hospital.

Health Care Bills
You have the right to receive an explanation of your bills and to have help in applying for financial programs when needed.

Ethical Concerns
You have the right to participate in ethical questions that arise during your care, including any conflict about End of Life decisions. There is an Ethics Committee that you can access to discuss your concerns. To access the ethics committee, contact the patient advocate, your physician or nurse, or the patient management department.

Privacy
You have the right to personal privacy, security, and confidentiality.

Research
You have the right to refuse to participate in any experimentation, investigational studies or clinical trails affecting your care or treatment.

Concerns About Your Care
You have the right to file a grievance with any staff member, Unit Director or the Patient Advocate. The Patient Advocate can be reached at 522-8641. Complaints can be filed after hours or on weekends by calling the operator and requesting the Administrator on Duty. You have the right to call the regulatory agencies listed below.

Safety
You have the right to a restraint and seclusion-free hospital stay, unless medically required or lesser restraining methods have failed to provide for your safety or safety of others. You have the right to receive care in a safe setting. You have the right to be free from any form of abuse, harassment, neglect or exploitation.

Protective Services
You have the right to access protective and advocacy services that can include guardianship and the need for protective interventions. See the phone number below.

Relationships with Memorial Medical Center
You have the right to know if MMC owns or operates any outside agencies that may provide services to you. You also have the right to know of any professional relationships among the individuals that may be treating you.

Your Responsibilities as a Patient:

Giving Information
You are responsible for providing accurate information about your health, including past illnesses, MMC stays and use of medications.

Following Instructions
You are responsible for following instructions as given. You are responsible for telling us if you do not understand the instructions or if you cannot follow them.

Consideration
You are responsible for being considerate of other patients, visitors, MMC staff, and for following MMC guidelines.

Health Care Bills
You are responsible for providing information for insurance and for working with MMC to arrange payments when needed.

Accepting Consequences
You are responsible for the outcomes if you do not follow the care, treatment and service plan.

Questions
You are responsible for asking questions when you do not understand your care, treatment and service, or what you are expected to do.

If you have any questions about your rights, please ask any team member of the hospital. You may also voice concerns or complaints to the following regulatory agencies:

New Mexico Medical Review Association	**1-505-998-9898**
Joint Commission on Accreditation of Healthcare Organizations	1-800-994-6610 or e-mail complaint@jointcommision.org
Centers for Medicare and Medicaid Services	1-877-267-2323
Protection and Advocacy	1-800-432-4682
Adult Protective Services Central Intake	1-866-654-3219
Child Protective Services Central Intake	1-800-797-3260
New Mexico Board of Medical Examiners	1-800-945-5845

Consult or Initial Visit History and Review of Systems: Memorial Cancer Center

Interpreter required? No☐ Yes☐ If yes, what language: _____
Learning barriers? No☐ Yes☐ Describe: _____

List your current Primary Physician/NP/PA, surgeon, subspecialists (examples: heart, kidney, GI, cancer, blood, lung, thyroid):

_____

_____

Do you want information about advanced directives/end of life care/ life support if you stop breathing or your heart stops? No☐ Yes☐
If yes, notify social worker.

Are you interested in learning about research studies that may offer you a new treatment for your disease? Yes☐ No ☐

Prior Radiation therapy (including radioactive iodine? _____

_____

_____

Do you have an implanted device in your body other than a pacemaker?

_____

Surgeries? If yes, what was done? when was it done? where was it done? List all: _____

_____

Medical History: (examples: diabetes, high blood pressure, heart, liver, kidney, or thyroid disease, stroke, arthritis, chronic pain, COPD, asthma, etc)

_____

_____

_____

_____

_____

_____

Lifestyle Habits:

Have you smoked tobacco? Yes ☐ No ☐
How many packs per day? ___and for how many years?___
If you quit smoking, when was your last puff? _____
Have you chewed tobacco? Yes ☐ No ☐ Still? Yes ☐ No ☐
Have you vaped? Yes ☐ No ☐ Still? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐
How many beers, mixed drinks, and/or wine do you have in one day?____ one week?___ one month___?
If you drink alcohol, have you ever:
felt the need to cut down? Yes ☐ No ☐
felt annoyed by criticism of your drinking? Yes ☐ No ☐
felt guilty about drinking? Yes ☐ No ☐
drink a morning "eye-opener"? Yes ☐ No ☐
If you quit alcohol, when was your last drink? _____

What harmful environmental substances have you been exposed to? (examples: asbestos, agent orange, insecticides)

_____

What drugs do you use or have you tried? (examples: cocaine, heroin, meth, marijuana) _____
When was the last time?_____

Exercise/Physical Activities:

What activities?_____

How many times per week and how many minutes per day?

_____

Healthcare Maintenance:

Last colonoscopy: _____Results:_____ Next due:_____
Ever had an EGD? Results:_____ Next due:_____
Last skin check by PCP or dermatologist? _____
Ever had a breast biopsy? Yes ☐ No ☐
Results: _____
Ever had a prostate exam? Yes ☐ No ☐
Results: _____ Last PSA? _____
Are you or your partner using birth control? Yes ☐ No ☐
What type of birth control? _____

Family History: (indicate alive or deceased; current age: age at cancer diagnosis and cancer type for each, if appropriate)

Father _____ Mother _____ Total Brothers/Sisters__/__
Brother(s)_____Sister(s)_____

_____

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

Consult or Initial Visit History and Review of Systems: Memorial Cancer Center

Support:

Marital Status:(*circle one*)
Single Married Divorced Widowed Partnered
Do you live alone? Yes ☐ No ☐
If no, list who lives with you:_____
Who do you rely on for support or help? _____
Do you have transportation? Yes ☐ No ☐
Do you have a place to stay in Las Cruces? Yes ☐ No ☐
Are you currently working? Yes ☐ No ☐
What type of work do you or did you do?
Do you have living children? Yes ☐ No ☐
How many? _____
Who is your decision maker if you can't speak for yourself?_____

For WOMEN:

Last PAP/GYN exam:_____ Results:____ Next due:_____
Last mammogram:_____Results: ____ Next due:_____
Are you or might you be pregnant? Yes ☐ No ☐
Date of last menstrual period: _____Length of period:_____
Age at first menses: _____ Number of pregnancies: _____
Number of live births: _____Age at first birth:_____
Number of living children: _____
Do you or have you ever taken
Hormone pills: Yes ☐ No ☐
Birth Control pills: Yes ☐ No ☐
Are you planning to have children Yes ☐ No ☐

General: None ☐

Fever Yes ☐
Recent loss of weight Yes ☐
If yes, how much? _____
Over what period of time? _____
Drenching night sweats Yes ☐
Fatigue or decrease in energy level Yes ☐
If yes describe: _____

Pain:

Experiencing pain **right now**? None ☐

If yes, rate on a scale of 1 to 10 with 10 being the worst pain you can imagine? ___/10

Where is pain located? _____
What does it feel like? Sharp? Dull? Constant?
_____
Does it travel or stay in one place? _____
If travels, to what part of body? _____
What makes it worse? _____
What makes it better? _____
Change in position ☐ Food ☐ Pain meds ☐
Other _____

Gastrointestinal: None ☐

Dentures Yes ☐
Nausea/Vomiting Yes ☐
Heartburn Yes ☐
Trouble swallowing Yes ☐
Constipation Yes ☐
Diarrhea (how many stools/day?)____ Yes ☐
Bloating Yes ☐
Abdominal Pain Yes ☐

Psychological: None ☐

Claustrophobic Yes ☐
Depression Yes ☐
Anxiety Yes ☐
Thoughts/feelings of hurting yourself Yes ☐

Neurologic: None ☐

Pins and needles sensation Yes ☐
Seizures Yes ☐
Muscle weakness Yes ☐
Headaches Yes ☐
Dizziness Yes ☐
Lightheadedness Yes ☐
Falls Yes ☐

Hematologic/Endocrine None ☐

Bleeding/easy bruising Yes ☐
Diabetes control Yes ☐
Sensation to hot or cold Yes ☐

Eyes/Mouth/Ears: None ☐

Double vision or loss of vision Yes ☐
Mouth sores Yes ☐
Toothache Yes ☐
Hearing Loss Yes ☐
Ringing in Ears Yes ☐
Sinus congestion Yes ☐

Respiratory: None ☐

Shortness of breath Yes ☐
When moving? Yes ☐
At rest? Yes ☐
Chest pain Yes ☐
Cough Yes ☐
Dry Yes ☐
Productive Yes ☐
Color of Sputum _____
Breathing troubles Yes ☐

Musculoskeletal: None ☐

Muscle aches Yes ☐
Joint swelling or stiffness Yes ☐
Bone pain Yes ☐
If yes, where? _____

Cardiovascular: None ☐

Pacemaker Yes ☐
Chest tightness Yes ☐
Chest pressure Yes ☐
Extra heart beats or palpitations Yes ☐
High blood pressure Yes ☐
Chest pain Yes ☐
Leg swelling Yes ☐

Genitourinary: None ☐

Urination problems Yes ☐
Bleeding Yes ☐
Burning Yes ☐
Change in color Yes ☐
Urgency Yes ☐
Hesitancy Yes ☐
Weak stream Yes ☐
Incontinence Yes ☐
Frequency Yes ☐

Skin: None ☐

Loss of hair Yes ☐
Change in skin color or rash Yes ☐
Lumps, bumps, thickening Yes ☐

Sexuality:

Gender preference? _____
Changes in sexual function? Yes ☐
Sexually active? Yes ☐
Birth control? Yes ☐
Type of birth control _____
Breast problems Yes ☐

For Women:

Pregnant? Yes ☐
Last menstrual period date _____
Length of period? _____
Any non menstrual bleeding Yes ☐

Patient (or caregiver) signature_____Date_____Time_____

Provider signature_____ Date_____ Time_____

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

Memorial Cancer Center
Radiation Oncology

Patient's Home Medication List

Patient Name:_____ Date of Birth:_____

Are you allergic to any medication? ☐ Yes ☐ No If yes, list the medication and symptoms or reaction (Example: severe rash, upset stomach, vomiting, difficulty breathing)

Medication	Describe Symptoms or Reaction

☐ Check box if you do not take any home medications, herbals, supplements, vitamins, teas or other remedies.

Date of last flu vaccination_____ Date of last pneumonia vaccination_____
Date of last tetanus vaccination_____

INSTRUCTIONS FOR COMPLETING YOUR MEDICATION LIST

- List ALL medications you take at home
  - o List prescription medications your doctor orders for you, medications you buy off the shelf, herbals, vitamins, supplements, teas or other remedies.
  - o Include medications you take every day and medications you take only when you need them, for example: allergy medicine, laxatives, antacids

- If you need more space, continue medication list on back.

Medication Name	Dose (mg, puffs, drops, units)	Route (mouth, patch, injection)	When you take it (how many times per day)	Reason (why you take it)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Memorial Cancer Center

Radiation Oncology

PHARMACY OF CHOICE

PLEASE SELECT (WRITE IN) ONE

___ FAMILY PHARMACY	1205 S. SOLANO
___ CVS PHARMACY	940 N Main St
___ CVS PHARMACY	3011 N. MAIN ST.
___ SAM'S CLUB	2711 N. TELSHOR
___ SAV-ON PHARMACY	1285 EL PASEO
___ SAV-ON PHARMACY	2551 E. LOHMAN AVE.
___ SAV-ON PHARMACY	2501 N. MAIN
___ WALMART	3331 RINCONADA BLVD
___ WALMART	1550 S. VALLEY
___ WALMART	571 S. WALTON BLVD.
___ WALGREENS	3990 E. LOHMAN (NEAR ROADRUNNER)
___ WALGREENS	3100 N. MAIN
___ WALGREENS	2300 E. LOHMAN (NEAR WALMART)
___ WALGREENS	1250 EL PASEO
___ WALGREENS	3490 NORTHRISE (NEAR WALMART)

- ___ OTHER: _____

Memorial
Cancer Center

Radiation Oncology

PHYSICIAN INFORMATION

(PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND ANY ADDITIONAL PHYSICIANS WHO HAVE PARTICIPATED IN YOUR CARE)

PRIMARY CARE PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

OTHER PHYSICIANS

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

Memorial Cancer Center

Radiation Oncology New Patient Process Guide

Welcome to our Clinic,

Consultation: Today you are here for a Radiation Consultation with one of our Radiation Oncologist, Dr. Gregory Willis or Dr. Jason Call. In today's visit you will first meet with one of our nurses to go over some of the information you filled out in your new patient packet and also to obtain any clinical information the doctor needs before meeting with you. The nurse will review this information with the doctor before seeing you. We suggest during this time you write down any questions or concerns you have, as you will be provided a lot of information during the consultation. We want to ensure at the end of you consultation all your questions are answered and you are comfortable with the information that was provided to you.

CT Simulation: If you choose to proceed with Radiation Treatment you will be given an appointment time for a CT simulation or at the doctors request it may be performed on the same day of the consultation. A CT simulation is a scan of the area of your body to be treated with radiation. The CT images acquired during your scan will be reconstructed and used to design the best and most precise treatment plan for you. You will **not start** radiation treatment on the day of your simulation unless the doctor informs you otherwise. After your CT simulation is performed one of our Radiation Therapists will provide you with a start date and time for Radiation Treatment. The CT simulation will be discussed with you in more detail before it is performed, in case you have additional questions.

Treatment Planning: The final process before starting Radiation Treatment is performed by the Dosimetrist and the Doctor to calculate a specialized radiation treatment plan just for you. You are not present in the clinic during this time, as the information obtained from your CT simulation will provide them with the information they need. We will also be obtaining authorization at this time for Radiation Treatment if required by your insurance carrier to ensure service will be covered for the entire course of your treatment. We thank you for choosing Memorial Cancer Center for your Radiation Oncology Services.

_____Patient/Guardian Signature Date_____

Memorial Cancer Center

RADIATION ONCOLOGY REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First name:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status : Single / Married / Divorce / Widow	
Place of Birth	Date of Birth:	Social Security #:	Age	Sex: ❑ Male ❑ Female	Best time for appt reminder call? AM PM	
Street address:		Home phone: ( )		Cell phone: ( )		
P.O. Box:	City:		State:	Zip Code:		
Occupation:	Employer:			Employer phone: ( )		

If retired: Date_____ If Disabled: Date:_____

INSURANCE INFORMATION

Person responsible for bill:	Date of Birth: / /	Address (if different):		Home phone #: ( )	
Is this person a patient here?					
Occupation:	Employer:	Employer address:		Employer phone #: ( )	
Is patient covered by insurance? ❑ Yes ❑ No					
Primary insurance:					
Subscriber's name:	Subscriber's S.S. #:	Date of Birth / /	Policy #:	Group #:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Secondary insurance (if applicable):	Subscriber's name:		Policy #:	Group #:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

Is your visit accident related? ❑ Yes ❑ No Type of accident: ❑ Auto ❑ Workers Comp ❑ Other Explain _____

BLACK LUNG PROGRAM.....❑ Yes ❑ No Spouse Retirement
Are the services for a patient under 65 and entitled to Medicare solely on the basis of ESRD?.....❑ Yes ❑ No Date:_____
Is the patient covered by an Employer Group Health Plan (an employer with 100 or more employees) where the primary insured (patient, spouse, or parent) is employed?.....❑ Yes ❑ No
Did the patient begin dialysis or enter the hospital for a transplant less than 33 months ago?.....❑ Yes ❑ No
IF ALL THREE YES, THE EGHP IS PRIMARY TO MEDICARE - Name and address of EGHP:_____

Are the services for this patient covered by the Veteran's Administration or other federal program such as the Public Health Service?
❑ YES - THE VA/PHS IS PRIMARY TO MEDICARE ❑ No

CONDITIONS OF TREATMENT

CONSENT TO TREATMENT: The undersigned hereby consents to the administration and performance of all diagnostic procedures and treatments which, in the judgement of my physician, may be considered necessary and advisable.
RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, the hospital or attending physicians may discuss portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the hospital's charge including, but not limited to, insurance companies, health care service plans, or workers' compensation carriers.
AGREEMENT OF INSURANCE BENEFITS: The undersigned authorizes whether he/she signs as agent or patient, direct payment to the hospital or physicians, medical groups and practitioners of any insurance benefits otherwise payable to the undersigned for his/her hospitalization at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

_____ Date:_____
Patient/Guardian Signature

Memorial Cancer Center

Radiation Oncology

CONSENT FOR FAMILY MEMBERS

Date: _____

I, _____, understand my rights as a patient and the role my providers take to ensure my privacy.

This letter is to inform the staff of Memorial Radiation Oncology permission to allow the following individuals access to my medical information.

I assign primary responsibility to the first person listed because I understand it is difficult for the staff at Memorial Radiation Oncology to speak to multiple family members.

	NAME	PHONE #	RELATIONSHIP
1			
2			
3			
4			

This list can be reviewed at any time.

Printed Name:_____

Signature:_____

Date:_____

EMERGENCY CONTACTS

Primary Contact:_____

Relationship:_____

Phone Number (s):_____

Secondary Contact: _____

Relationship:_____

Phone Number(s):_____

AUTHORIZATION TO OBTAIN INFORMATION
FROM OTHER PROVIDERS
NAME: _____
DOB: _____
SOC SEC:

This authorization is to OBTAIN medical records from another provider. Please fill in **ALL** the information requested; leave **NO** blanks. Print full name and address of individual or institution from whom records are to be requested.

Records Requested From: _____

NAME _____

ADDRESS _____

CITY_____STATE_____ZIP CODE_____

The purpose of this disclosure is: _____

Please specify the extent of information you wish released.

A. Records of inpatient, outpatient, or emergency service for the following condition or injury:

_____

B. Records of the period from _____ to _____

C. Specific records needed are:

- ☐ admission face sheet
- ☐ discharge summary
- ☐ history/physical exam
- ☐ operative report
- ☐ pathology report
- ☐ consultation report
- ☐ orders/progress notes
- ☐ laboratory report
- ☐ x-ray report
- ☐ electrocardiogram report
- ☐ emergency department report
- ☐ entire chart
- ☐ other: _____

D. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness, I understand that I have a right to examine and copy any information disclosed under the terms of this release (N.M. Stat. Ann § 43-1-19.) With the exception of mental health records, if the patient is a minor under age 14, the patient and legal representative must sign here and below. At least one signature is needed in this section in ALL cases.

Signature: _____Date/Time_____Signature: _____Date_____

The authorizing party may revoke this authorization at any time by notifying the individual/institution from which records were requested. I understand that I can receive treatment at Memorial Medical Center even thought I have not signed an authorization to obtain my medical records from other providers.

I authorize you to provide the above medical information to Memorial Medical Center. I waive all provisions of law relating to the disclosures hereby authorized.

Patient Signature_____ Date_____

If patient unable to sign, give reason: _____

Signature of legally authorized representative:_____ Date _____

Relationship to patient: _____Witness Signature: _____ Date _____

PLEASE ADDRESS REPLIES TO THE ATTENTION OF:

MMC Radiation Oncology
2450 S. Telshor Blvd. Building B
Las Cruces, NM 88011
Phone: 575-556-5800
Fax: 888-974-0806

821-031 (New 05/19)

Memorial Cancer Center

Radiation Oncology
2450 S. Telshor Blvd, Bldg B
Las Cruces NM 88011
Phone: 575-556-5800
Fax: 888-974-0806

AUTHORIZATION FOR RELEASING INFORMATION FROM MEDICAL RECORDS

NAME_____

DATE OF BIRTH_____

SOC. SEC. #_____

PT. ACCT. #_____

This authorization is to RELEASE MEMORIAL MEDICAL CENTER MEDICAL RECORDS. Please fill in **ALL** the information requested; leave **NO** blanks. This authorization will not be considered valid if all the information is not provided.

Send To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Memorial Medical Center to provide the above-named person(s) or company access to my medical records for the purpose of review, examination, and provision of such copies as may be requested.

The purpose of this disclosure is: _____
Please specify the extent of information you wish released.

A. Records of Inpatient, Outpatient, or Emergency Services whether such records were generated at Memorial Medical Center or were obtained from a previous provider, which relate to my care and treatment, except (specify what kind of information you do NOT want released):_____

_____

B. Records of the period from _____ to _____

C. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness I understand that I have a right to examine and copy any information disclosed under the terms of this release (N.M. Stat. Ann. § 43-1-19). If the patient is a minor, the patient and the legal representative must sign here and below. At least one signature is needed in this section in **ALL** cases.

Signature _____ Date_____ Signature _____ Date_____

This authorization shall be considered invalid after 6 months or 60 days for drug and alcohol abuse records, from the date of signing. Medical information gathered after the date of authorization signing will not be released. The authorizing party may revoke this authorization at any time by notifying MMC in writing. Send revocation to: Health Information Management Director, Memorial Medical Center, 2450 S. Telshor Blvd., Las Cruces, NM 88011-5076. I agree that my revoking the authorization will not have any effect on any information which MMC has already released before they received my written notice to revoke this authorization.

I understand that I can receive treatment at Memorial Medical Center even though I have not signed an authorization for release of my medical records.

In furtherance of this authorization, I do hereby waive all provisions of law relating to the disclosures hereby authorized.

Patient Signature _____ Date_____

If patient unable to sign, give reason _____

Signature of legally authorized representative _____ Date_____

Relationship to patient _____ Witness' Signature_____ Date_____

ANY REDISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED

ROIAUTH

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance con tract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the ho spital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pe nding legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non -payment of the balance on the account. I understand that all physicians and surgeons, including the radiol ogist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's p ayment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, g overnment health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benef its and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new service s and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescrip tion drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Med icare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment

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CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS. HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, per individual state regulations, most physician assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask my Health Care Provider to verify if they are a Hospital employee or an independent contractor.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.
    I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S):** I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

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Las Cruces, NM

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CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

17. **CONSENT TO RECORDING:** I consent to photographs, video images, and/or audio monitoring/recordings as it may be used to document patient care, security, or for the purposes of healthcare operations. I hereby consent to the use of such technologies in the course of my treatment and medical condition and understand that such recordings may be kept as a part of my medical record.

18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive
    ☐ I have not executed an Advance Directive
    ☐ I would like to formulate an Advance Directive and receive additional information

19. **OTHER ACKNOWLEDGEMENTS:**

    a. Personal Valuables: I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.

    b. Smoke Free Facility Policy: The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

    c. Weapons / Explosives / Drugs: I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

20. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

21. **AGREEMENT AS TO FORUM SELECTION (where lawsuits shall be filed):** The patient or patient's representative, and Memorial Medical Center, including employees and agents Memorial Medical Center, rendering or providing medical care, health care, or safety, professional or administrative services in any way related to health care to patient (all of the above referred to as "health care"), agree: in the event of a dispute or claim, any lawsuit, which in any way relates to health care provided to the patient shall only be brought in the Third Judicial District Court, Dona Ana County, Las Cruces, New Mexico, and in no event will any such lawsuit ever be brought in any other place. The provisions of this paragraph, as to where suit shall be brought, are mandatory.

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CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient or Legal Representative for Health Care Hospital Services if Other Than Patient

Date and Time

Relationship to Patient

Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

Signature of Witness

Date and Time

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