



Radiotherapy Centers
OF KENTUCKIANA

David P. Musich, MD
Lawrence Hochman, DO
Matthew Forsthoefel, MD
Diplomates American Board of Radiology



Dear: _____

You have an appointment with Dr. _____ on

(date) _____ at (time) _____ : _____ AM / PM at the following center:

Radiotherapy Centers of Kentuckiana – Jeffersonville
1322 Spring Street
Jeffersonville, IN 47130
tel/ 812.285.6000 fax/ 812.285.6010

Radiotherapy Centers of Kentuckiana - Louisville
3920 Dupont Square South, Suite B
Louisville, KY 40207
tel/ 502.409.9701 fax/ 502.409.9717

Please arrive 15 minutes prior to your scheduled appointment time.

To make the registration process smoother, we ask that you complete the enclosed forms and bring the following items along with you to the appointment:

- This packet with all forms completed
- Please bring a list of all your medications and how you take them. You may wish to bring your medications with you.
- Your insurance card(s)
- Co-payment if required by your insurance

If you have any questions, please call our office at the numbers listed above.

Sincerely,

The Physicians and Staff of Radiotherapy Centers of Kentuckiana

***If you are unable to make your appointment, please call our office at least 24 hours in advance.**



David Musich, MD
 Dr. Lawrence Hochman, DO
 Matthew Forsthoefel, MD

Patient Registration Form

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number _____ Cell or Home

Gender assigned at birth: Male Female Preferred Pronouns: She/Her He/Him They/Their

Ethnicity: Hispanic/Latino Yes No Declined

Race: White African American Asian/Pacific Islander Declined

Marital Status: Married Single Divorced Widowed Other _____

Email: _____ Preferred Language: _____

Employed: Y or N Employer: _____

Disabled: Y or N Date: _____

Retired: Y or N Date: _____

Referring Physician: _____ Primary Care Physician: _____

Assignment of Benefits / Financial Responsibilities

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice Care? ____ Yes ____ No

Name of Facility _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Insurance Information:

Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____

Primary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____

Primary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____



David Musich, MD
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 Matthew Forsthoefel, MD

Financial Responsibilities:

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Radiotherapy Centers of Kentuckiana (RCK).
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to RCK. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.
4. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to RCK.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from RCK.

THIS AGREEMENT I CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient Signature: _____

Date: _____

Responsible Party Signature: _____ Relationship: _____

Date: _____

Patient Name _____
 MRN _____
 Today's Date _____

Radiotherapy Centers of Kentuckiana
 New Patient Paperwork

Medical History: (Please check all that apply)

Seasonal Allergies		Gallbladder Disease		IBS / Crohn's Disease	
Anxiety		GERD (Acid Reflux)		Neuropathy	
Arthritis		Heart Disease		Osteopenia/Osteoporosis	
Asthma		Heart Attack		Rheumatoid Arthritis	
Bladder Incontinence		Hemorrhoids		Seizure Disorder	
COPD/Emphysema		High Blood Pressure		Skin Conditions_____	
Dementia		High Cholesterol		Stroke	
Depression		HIV/AIDS		Thyroid Disorder	
Diabetes		Hepatitis / TB		Ulcerative Colitis	

Please list any additional medical conditions you have that are not mentioned above:

Do you have a pacemaker, internal defibrillator, or any other implanted electronic device? Yes No

Have you ever had a joint replacement surgery? Yes No

If yes, which joint? _____

Have you ever received an organ transplant? Yes No

If yes, which organ(s)? _____

Please list any surgeries, procedures, or hospitalizations:

Type of Surgery, Procedure, Hospitalization	Where was it performed?	When?

Cancer Screenings and Prior Cancer Treatments

(FEMALE PATIENTS ONLY)

Date of last Mammogram? _____

Location? _____

Date of last Pap Smear? _____

Location? _____

Age of first menstrual period? _____

Age of last menstrual period? _____

Do you experience Urinary Incontinence? Yes No

Have you had a bone density scan? (DEXA) Yes No

If yes, where? _____

Number of Pregnancies? _____

Number of Miscarriages? _____

Number of Deliveries? _____

Age at first pregnancy? _____

Have you ever taken any hormones, such as birth control, estrogen, androgens? Yes No

Is there a possibility you could be pregnant? Yes No

Patient Name _____
 MRN _____
 Today's Date _____

Radiotherapy Centers of Kentuckiana
 New Patient Paperwork

Have you had one of the following colorectal cancer screenings?

- Colonoscopy
- Fecal Occult Blood Test (FOBT)
- FIT Test
- Flexible Sigmoidoscopy

If yes, date(s) _____ and location(s) _____

Have you ever been diagnosed with cancer before? Yes No

If yes, please answer the questions below:

What type of cancer? _____

Who Diagnosed you? _____ When? _____

Have you ever received any radiation or cobalt treatments? (Includes treatments for birthmarks and dermatology reasons) Yes No Location? _____

Have you ever received Chemotherapy? Yes No

If yes, please list what drugs: _____

Have you ever received any type of hormone therapy for cancer? Yes No

If yes, please list the medication and date taken: _____

Family History

Relationship:	Current Age	List Medical Conditions:	If Deceased, age and cause of death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Other:			

Social History

Do you use any type of tobacco products? Never Yes Previously (year quit _____)

If yes, what type of tobacco products do you use? Cigarettes Pipe Cigar Chew/Dip

Frequency of use: _____ packs per day

Do you drink alcohol beverages? Never Occasionally Regularly

If regularly, how many drinks per day _____? per week _____?

How many times in the past year have you had four or more drinks in one day? _____

Do you use marijuana or recreational drugs? Yes No

Have you ever worked in an occupation that involved exposure to cancer causing chemicals, fumes or other carcinogens? Yes No

If yes, what exposure? _____ For how long? _____

Patient Name _____
 MRN _____
 Today's Date _____

Radiotherapy Centers of Kentuckiana
 New Patient Paperwork

Medication and Immunization List

Have you received an influenza (flu) vaccine this season? Yes No If yes, date _____
 Have you received a pneumococcal (pneumonia) vaccine? Yes No
 Have you received a COVID vaccine? Yes No

List any allergies to any medications or drugs (including contrast, iodine, etc..)

Medication	Type of reaction?

List any Medications you are currently taking, including OTC, vitamins and supplements:

Name of Medication	Strength/Dose	Frequency

Screening for Depression (PHQ-2)

Are you currently under any treatment for mental illness or depression? Yes No

Name of Provider: _____

Over the past 2 weeks, how often have you been bothered by any of the following	Not at all	Several days	More than ½ of the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Patient declined to answer screening questions _____

Patient Signature _____ Date _____

Patient Name _____

MRN _____

Today's Date _____

Radiotherapy Centers of Kentuckiana

New Patient Paperwork

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Under HIPAA, we may discuss your protected health information, including **medical care or financial information** with individuals involved in your care if you are not present or do not have the capacity to agree or object, if in the professional judgment of Radiotherapy Centers of Kentuckiana (RCK) physician or other caregiver, we conclude that the disclosure is in your best interest. The disclosure is limited, in this circumstance, to protected health information that is directly relevant to that individual's involvement in your care. If you would like to identify specific individuals to whom we may make the foregoing disclosures, such as in the event RCK is unable to reach you or in response to an inquiry, please list them here:

1) _____
Name / Relationship _____ Date _____

2) _____
Name / Relationship _____ Date _____

Communications: Please specify ways in which you prefer for us to communicate with you. This is to include: appointment reminders, test results, prescription refills and financial communications.

Phone Number: Yes No Leave messages on my answering machine/voicemail
 Yes No Leave messages with any other person answering the phone
 Yes No Attempt to contact me via my email address **Email** _____

**** By providing your cell number and email you are agreeing to be contacted for appointment reminders and physician surveys.**

I understand the contact information on the Registration Form will be relied upon to communicate with me regarding my medical and financial information until such time as I notify RCK in writing of a change.

Printed Name

Date

Signature of Patient/Guardian

Reason Patient Unable to Sign/Guardian Relationship

Radiotherapy Centers of Kentuckiana is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Radiotherapy Centers of Kentuckiana.

Patient Name (Please print): _____

Signature: _____ Date: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____