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.

<u>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:</u>

□ 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

Social Security Number: _______________________

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: _____________________________

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Preferred Pharmacy

Name of Pharmacy: ____

Phone Number: ____

Address: ____

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.

Photographs and Recording Devices: Radiotherapy Centers of Kentuckiana requires that patients to notify the provider prior to any recording to ensure other patients' confidentiality. We reserve the right to decline any recordings of any type. Additionally, we do not permit or tolerate hidden recording devices from our patients and Radiotherapy Centers of Kentuckiana does not consent to the video or audio recording of your visit without provider or staff permission. This includes but not limited to physician visits, CT scans, and/or radiation treatments.

THIS AGREEMENT 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 _______________________

Radiotherapy Centers OF KENTUCKIANA

The US Oncology Network

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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): ______________________________