SOUTHLAND RADIATION ONCOLOGY NETWORK
www.southlandradiation.com

10226 Lakewood Blvd, Downey, CA 90241
554 E. San Bernardino Road, Suite 105, Covina, CA 91723
1555 N. Orange Grove Avenue, Pomona, CA 91767
626-331-6866 626-331-6773

15980 Bear Valley Road, Victorville, CA 92395
760-513-6001 760-513-6002

INSTRUCTIONS FOR YOUR FIRST VISIT

Welcome to Southland Radiation Oncology Network! To ensure the highest level of patient satisfaction and comfort as well as efficiency on our behalf, the following protocol will be followed on your initial visit to our facility. Please acknowledge that these steps are devised with the patient in mind so that we may provide you with the highest level of treatment. Thank you.

1. Upon immediate arrival to the center, the patient is asked to check in with the front receptionist. He/she will give the patient all necessary information and consent forms that are required before treatment and consultation may occur.

2. After the forms have been completed by the patient, an employee or the Physician will lead the patient into a private exam room. The physician will complete his initial consultation of the patient in this room. This procedure may include, but not limited to, a physical exam, oral questionnaire and/or discussion.

3. Depending on the result of the initial consultation, a course of treatment will be decided between the physician and the patient. Once treatment has been decided, consent forms must once again be completed. These forms will typically consent photographs of the patient, medical release forms, and consent to the medical treatment.

4. If applicable, the patient will be taken into a treatment room to plan their treatment. During this time, please be aware that the therapist, therapist technician, physicist, and physician will all be entering your treatment room to design a treatment plan specifically for the individual patient. The process is crucial to your treatment.

The initial appointment will take a minimum of one and a half (1.5) hours. Once again please keep in mind that this process has been designed to benefit the patient and their well being.

____
Print Name

______________________________ ____________________
Signature Date

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PATIENT INFORMATION

PREFIX: ☐ DR. ☐ MR. ☐ MRS. ☐ MS.	PATIENT NAME (FIRST NAME,LAST NAME):	SEX:	AGE:	BIRTHDATE: / /
CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	SOCIAL SECURITY NUMBER: - -	DRIVER'S LICENSE #:		
ADDRESS:	CITY:	STATE:	ZIP CODE:	PHONE:	CELL PHONE:
EMPLOYER OF PATIENT:	OCCUPATION:	ADDRESS:	PHONE:	
PARENT NAME (IF PATIENT IS A MINOR):	PARENT NAME (IF PATIENT IS A MINOR):			
REFERRING PHYSICIAN NAME:	REFERRING PHYSICIAN ADDRESS			
IN CASE OF EMERGENCY CONTACT:	ADDRESS:	PHONE:		

CURRENT INSURANCE COVERAGE

Please give us all pertinent patient information regarding your insurance coverage. If you have coverage by more than one carrier supply information on both carriers.

IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PREADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE COMPANY:	NAME OF INSURANCE COMPANY:
ADDRESS OF INSURANCE COMPANY: ______________________ ______________________ ______________________	ADDRESS OF INSURANCE COMPANY ______________________ ______________________ ______________________
GUARANTOR (IF OTHER THAN PATIENT):	GUARANTOR (IF OTHER THAN PATIENT):
SUBSCRIBER NUMBER:	SUBSCRIBER NUMBER:
GROUP NUMBER:	GROUP NUMBER:

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REFERRING PHYSICIAN INFORMATION

It is important to provide you with continuity of care; we need the name and phone number of your referring physicians. Example: Medical Oncologist, Primary Care Physician, Surgeon, etc.

Physician Name: ______________________ Phone: ____________________
Address: ______________________ Fax: ____________________
____
____

Physician Name: ______________________ Phone: ____________________
Address: ______________________ Fax: ____________________
____
____

Physician Name: ______________________ Phone: ____________________
Address: ______________________ Fax: ____________________
____
____

Physician Name: ______________________ Phone: ____________________
Address: ______________________ Fax: ____________________
____
____

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HEALTH QUESTIONNAIRE

Height: ___________ Weight: _____________ Notes: ____

Allergies to Medications: ☐ Yes ☐ No
If yes, please indicate reactions and medications: ____

Medical History (Please list past and current conditions):

Medical Conditions	Surgeries	Medications

Family History:

	If Living:		If Deceased:		Have any of your blood relatives ever had cancer?		
	Age	Health (Good, Average, Poor)	Age (At Death):	Cause	Family Member	Type of Cancer	Age of Diagnosis
Father							
Mother							
Sibling(s)							
Spouse							
Child(ren)							

Social History:

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week? ____________________________________

Do you smoke tobacco? ☐ No ☐ Yes If yes, how many packs a day? ____

Have you ever smoked tobacco? ☐ No ☐ Yes If yes, how many years have you smoked? _____________________

Have you been vaccinated with the influenza vaccine: ☐ No ☐ Yes
If yes, when was your last influenza vaccination administered? ____

Are you employed? ☐ No ☐ Yes If yes, what is your occupation? __________________________________

Would transportation to SRON for daily treatments be difficult for you? ☐ No ☐ Yes
If yes, please specify: ____

System Review:

Do you have any of the following recently?

General:	Yes	No
Fevers	☐	☐
Night sweats	☐	☐
Chills	☐	☐
Recent weight change	☐	☐

Genitourinary:	Yes	No
Frequent urination	☐	☐
Night time urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Kidney Stones	☐	☐

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Skin:	**Yes**	**No**
Hives	☐	☐
Eczema	☐	☐
Rash	☐	☐
Abnormal Pigmentation	☐	☐

Head, Eyes, Ears, Nose, Throat:	**Yes**	**No**
Eye disease or injury	☐	☐
Do you wear glasses?	☐	☐
Change in vision	☐	☐
Nose bleeds	☐	☐

Respiratory:	**Yes**	**No**
	☐	☐
Shortness of breath	☐	☐
Cough	☐	☐
Wheezing	☐	☐

Cardiovascular:	**Yes**	**No**
Chest Pain	☐	☐
Shortness of Breath while walking or lying down	☐	☐
Difficulty Walking Two Blocks	☐	☐
Swelling of Hands, Feet or Ankles	☐	☐
Heart Murmur	☐	☐

Gastrointestinal:	**Yes**	**No**
Peptic Ulcer (Stomach or Duodenal)	☐	☐
Bleeding with Bowel Movements	☐	☐
Black Stool(s)	☐	☐
Recent Changes(s) in Bowel Habits	☐	☐
Frequent Diarrhea	☐	☐
Heartburn or Indigestion	☐	☐

Musculoskeletal:	**Yes**	**No**
Joint Pain	☐	☐
Joint Swelling	☐	☐
Injuries or Joint Fractures	☐	☐

Psychiatric:	**Yes**	**No**
Depression	☐	☐
Anxiety	☐	☐
Hallucinations	☐	☐
Paranoia	☐	☐

Neurological	**Yes**	**No**
Fainting Spells	☐	☐
Convulsions	☐	☐
Paralysis	☐	☐
Headaches	☐	☐

Hematologic:	**Yes**	**No**
Anemia	☐	☐
Have you had difficulty with excessive bleeding?	☐	☐

Endocrine:	**Yes**	**No**
Excessive Thirst	☐	☐
Intolerance to Heat or Cold	☐	☐

Gynocological: (Female Patients Only)

Date of first of last menstruation……………… ____________
Age of first menstruation………………………… ____________
Number of Pregnancies………………………… ____________
Number of Children……………………………… ____________
Number of Miscarriages……………………… ____________
Age at First Live Birth…………………………… ____________
Date of Last Pap Smear………………………… ____________

	Yes	**No**
Have you ever taken hormone replacement medications?	☐	☐
If yes, what type? ______________________		
Have you ever taken birth control pills?	☐	☐
If yes, how long? ______________________		
Have you ever breast-fed?	☐	☐

Date of last mammogram? ______________________
List any other tests: ______________________
____

Breast History:	**Yes**	**No**	**Right**	**Left**	**How Long?**
Do you have any lumps in your breasts?	☐	☐	☐	☐	____________
Do you have any breast pain?	☐	☐	☐	☐	____________
Do you have any discharge?	☐	☐	☐	☐	____________

Please list any other symptoms:
____

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES DATA COLLECTION FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, & DISABILITY STATUS

What is your ethnicity?
☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rica
☐ Yes, Cuban
☐ Yes, Another Hispanic, Latino/a or Spanish origin

What is your race? (One or more categories may be selected)

☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian Indian
☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Other Asian	☐ Guamanian or Chamorro	☐ Samoan
☐ Native Hawaiian	☐Other Pacific Islander		

What is your sex?
☐ Male ☐ Female

How well do you speak English? (5 years old or older)
☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak a language other than English at home? (5 years old or older)
2. What is this language? (5 years old or older)
☐ Spanish ☐ Other language (Identify) ______________________________

Are you deaf or do you have serious difficulty hearing?
☐ Yes ☐ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses?
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
☐ Yes ☐ No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)
☐ Yes ☐ No

Do you have difficulty dressing or bathing? (5 years old or older)
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
☐ Yes ☐ No

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PERMISSION TO RELEASE MEDICAL INFORMATION

To Whom It May Concern:

I, ____, hereby authorize you to send all
PLEASE PRINT NAME
medical records, reports, and/ or radiology films to the above named physician/ institution as soon as possible.

Thank you for your timely response.

____ ____________________
Patient (Or Person Authorized to Consent) Date

____
Witness

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PATIENT AGREEMENT FORM

TREATMENT MEDICAL CONSENT: I consent to the administration and performance of all radiation oncology related procedures which, in the judgment of the physician/healthcare practitioner may be considered necessary and advisable. I also agree that should I elect to suspend or discontinue treatment against the consent of my physician, then Covina Cancer Care Medical Center Inc. (dba. Southland Radiation Oncology Network) will not be liable for any consequence of that decision.

CONSENT TO PHOTOGRAPH: The undersigned hereby authorizes Southland Radiation Oncology Network ("SRON") and the attending physician(s) to photograph and permit other persons to photograph me while under the care of the above institution, and agrees that any images derived thereof are to be used only for the treatment record and educational purposes.

INDEPENDENT CONTRACTORS: I acknowledge that the radiation oncologist(s) and radiation physicist(s) involved in my care are not employees or agents of SRON. It is expressly understood by me that the individual physicians and physicists involved in my care are engaged by SRON as "Independent Contractors" rendering professional services. Such Contractors operate independently without oversight by SRON in rendering their respective medical care.

RELEASE OF INFORMATION & HIPAA CONSENT: In order to obtain reimbursement, I understand that portions of my medical record may be disclosed to any person or corporation (or any agent of such person or corporation) which will be affiliated for all or any portion of charges by SRON, including, but not limited to, insurance companies, health care service plans, worker's compensation carriers and employers. I hereby acknowledge that a copy of the current notice will be available in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment by request.

ASSIGNMENT OF BENEFITS: I hereby authorize that any payment that is made payable to me from my insurance company will be forwarded to SRON within five (5) business days. Payment shall not exceed SRON's regular charges for treatment. I understand that I am financially responsible to SRON and its affiliates for charges not covered by my insurance carrier.

FINANCIAL AGREEMENT: In consideration of the services provided, I understand and agree that I am held financially responsible (undersigned may be patient, agent or financial responsible party) for all charges, whether or not charges are covered by my insurance. In accordance with the medical insurance policy current rates and terms, all payments and/or balance owed must be forwarded and made payable to SRON. **ALL CO-PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE**. If it is necessary to utilize an attorney to enforce this agreement, or collect any judgment based upon this agreement, then I will be financially responsible and liable for all court costs and attorney fees accrued, including bankruptcy and appellate court.

AUTHORIZATION TO TRANSFER FUNDS: I understand should a credit balance appear on my account with SRON, then I authorize that use of credit balance be applied to any unpaid balance due to SRON. Furthermore, once all claims have been processed, I may receive a refund from SRON for any excess of funds that were paid at the time of service prior to the submission of claim.

CERTIFICATION: I certify that I have read, agreed and accepted the above terms and conditions and I may receive a copy of this agreement upon request.

PREGNANT: Are you pregnant and/or have reason to suspect that you may be pregnant? □ **YES** □ **NO**
If YES, please immediately notify the front office staff member AND radiation therapist prior to any treatment.

____ Date ____________________

Patient, or Patient's Agent or Representative
*If patient is incompetent, a legal guardian or conservator must sign.

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ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider.s clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider.s associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party.s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party.s own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover noneconomic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that arbitration rules within the State of California shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. ________. Effective as the date of first professional services. If any provision of the Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Print Name: ____ Date: ________________________

Patient Signature: ***X***____
(Or patient Representative) (Indicate relationship if signing for patient)