LITTLE ROCK CANCER CLINIC, P.A.

PLEASE PRINT THE FOLLOWING INFORMATION:

Last Name First, MI Home # Marital Status Race

Street Address City State Zip

Employer Name Address Work Phone

Date of Birth Social Security Number Driver's License Number

Spouse (Last, First, MI) Date of Birth Social Security Number

Spouse's Address, If Different for Yours Home Phone

Spouse's Employer & Address Work Phone

Nearest Relative NOT Living With You Relationship to You Phone Number

Person to Notify in case of Emergency Relationship to You Phone Number

Family Physician Referring Physician (If Different)

INSURANCE INFORMATION

Primary Insurance Name Address Phone Number

Policy/I.D. Number Group Number

Secondary Insurance Name Address Phone Number

Policy/I.D. Number Group Number

Patient Signature Date

FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. If you have any questions or concerns about our payment policies, please do not hesitate to contact our office.
We accept assignment on Medicare, Blue Cross, Medicaid and certain HMO's. We will file claims with up to two insurance plans when you furnish us correct information. However, you must understand that:

1. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, whether your insurance company pays or not. Not all services are covered benefits in all contracts.
3. Fees for these services, along with unpaid deductibles or Co-Pays, are due at the time of treatment.

Patient's Signature_____ Date_____

INSURANCE ASSIGNMENT

I request that payment of authorized medical benefits be made directly to Little Rock Cancer Clinic for any services furnished me by Dr. Stella Kamanda and/or Dr. James Beck. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable to related services.

Patient's Signature_____ Date_____

APPOINTMENTS

If you are unable to keep your appointment, you must notify our office immediately so we can use the open slot for other sick patients. Also, if you are over 30 minutes late for your appointment, and haven't called to notify us, you will be rescheduled to another day and time.

Patient's Signature_____ Date_____

LITTLE ROCK CANCER CLINIC

Name_____ Date_____

Past Surgical – Please list all surgical procedures that you have had, beginning with the first and ending with the most recent.

Gastric Bypass YES _____ NO _____

A) Procedure_____ Date_____

Hospital_____ Surgeon_____

B) Procedure_____ Date_____

Hospital_____ Surgeon_____

C) Procedure_____ Date_____

Hospital_____ Surgeon_____

Past Medical – Please check any serious health problem and approximate year it began.

___Rheumatic Fever	___Diphtheria	___Typhoid Fever
___Malaria	___Pneumonia	___Pleurisy
___Hepatitis	___Gall Stones	___Kidney Stones
___Heart Attack	___High Blood Pressure	___Epilepsy
___Diabetes	___Thyroid Disease	___Bleeding Tendency
___Anemia	___Allergies	___Kidney Disease
___Sinusitis	___Photosensitivity	___X-Ray or Radium Treatment

OTHER MAJOR ILLNESSES: _____

_____

SOCIAL

1) Married___ Single___ Divorced___ Widowed___ Other_____
2) Number of Living Children_____ How many live nearby_____
3) Your Education Level_____

FAMILY

1) Parents: Mother – Living___ Deceased___ Cause_____
   Father – Living___ Deceased___ Cause_____
2) Siblings: How many are living_____
   How many are deceased_____
3) Any family history of cancer or blood disorders? _____
   If yes, please list relationship and disease _____

HABITS:

1) Smoke___ If yes, how much_____ How long_____
2) Alcohol Use_____

OB/GYN (Females Only)

1) Number of Pregnancies_____
2) Number of Live Births_____ Number of Miscarriages _____
3) Last Menstrual Period_____ Problems_____
4) If post menopausal, surgical or natural _____

MEDICATIONS – Please list all medications you are presently taking:

1) _____
2) _____
3) _____
4) _____

ALLERGIES – Please list all allergies to drugs

1)_____ 3)_____
2)_____ 4)_____

R.O.S. GENERAL – Have you in the *past 2 months* had:

A) Any Weight change___ How much_____
B) Any Fever___
C) Night Chills___
D) Any Pain___ Location_____
E) Any Weakness or easily tired___

		YES	NO
HEENT			
Head--	Headaches	___	___
	Fainting	___	___
	Seizures	___	___
Ears--	Hearing Problems	___	___
	Infections	___	___
Nose--	Bleeding	___	___
	Allergies	___	___
Mouth--	Dentures	___	___
	Ulcers	___	___
	Hoarseness	___	___
RESPIRATORY			
Lungs--	Shortness of Breath	___	___
	Coughing up of Blood	___	___
	Pleurisy – Breathing pain	___	___
	Chronic Cough	___	___
	Last Chest X-Ray (date)_____		

		YES	NO
CARDIOVASCULAR			
Heart--	Chest Pain	___	___
	Shortness of breath while lying down	___	___
	Awaken at night short of breath which is relieved by sitting	___	___
	Palpitations	___	___
	Heart Murmurs	___	___
	Swelling of Ankles	___	___
GASTROINTESTINAL			
Stomach--	Difficulty in swallowing	___	___
	Change in bowel habits	___	___
	Blood in stool	___	___
	Dark or tar-colored stool	___	___
	Nausea or vomiting	___	___
	Vomiting blood	___	___
	X-Ray of intestines/stomach/colon (date) _____		
GENITOURINARY			
Kidneys--	Get up at night to urinate	___	___
	Infection in bladder of kidney	___	___
	Difficulty urinating	___	___
	Blood in urine	___	___
	X-Ray of Kidneys (date)_____		
MUSCULOSKELETAL			
Bones & Muscles--	Bursitis	___	___
	Tendonitis	___	___
	Arthritis	___	___
	Back Problems	___	___
	Neck Pain	___	___
	Muscle or leg weakness	___	___
NEUROLOGICAL			
Nerves--	Dizziness	___	___
	Fainting	___	___
	Irritability	___	___
	Seizures	___	___
Skin--	Rashes	___	___
	Itching	___	___
LYMPH NODES			
	Enlarged	___	___
	Where _____		

LITTLE ROCK CANCER CLINIC, P.A.

500 S. University Avenue, Suite 811, Little Rock, Arkansas 72205
501-661-1822 Fax 501-666-0266

Stella Kamanda, M.D., Ph.D. **James F. Beck, M.D.**

Receipt of Notice of Privacy Practices
Written Acknowledgment Form & Authorization to Disclose

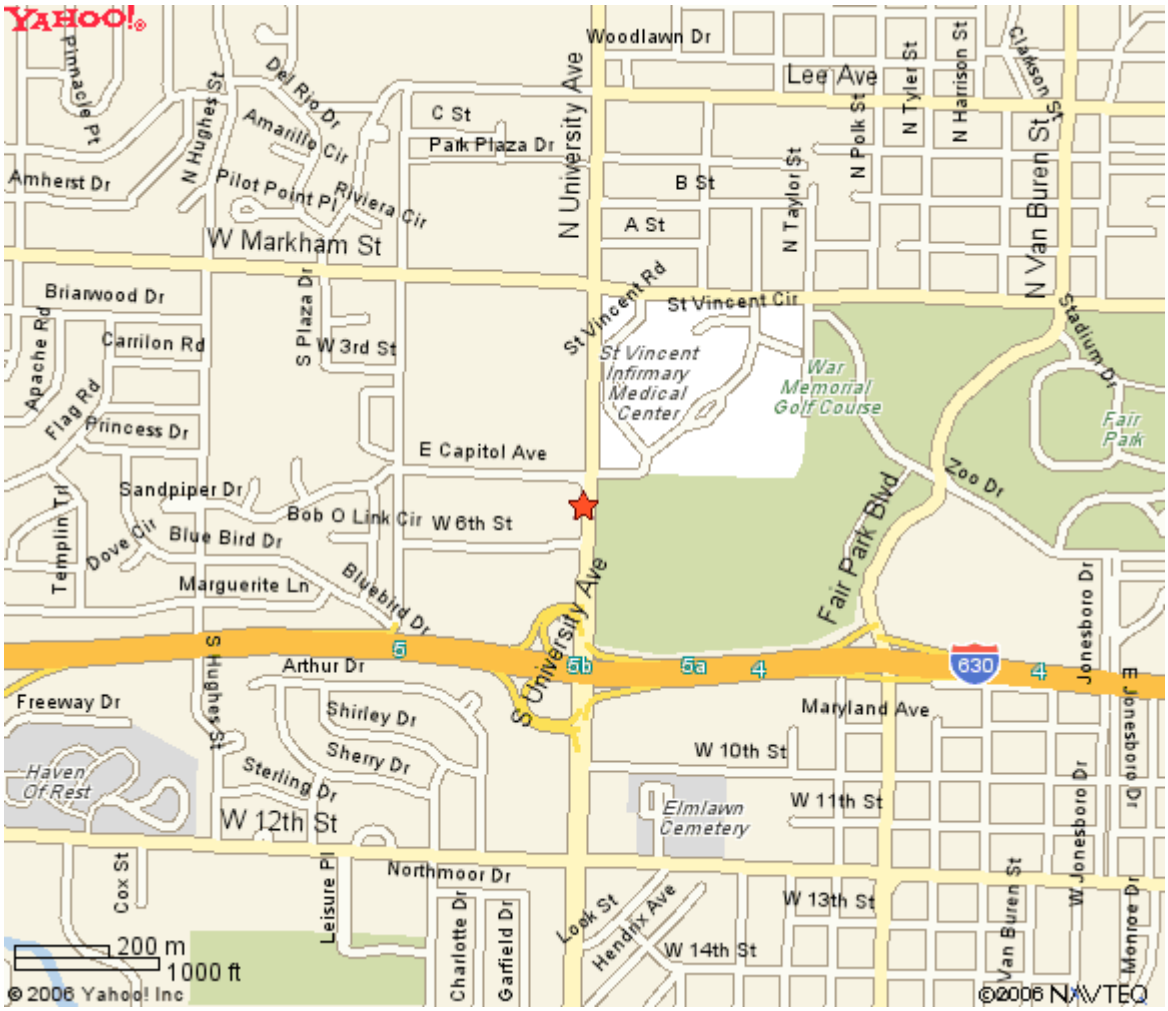
I, _____, have received a copy of Little Rock Cancer Clinic's Notice of Privacy Practices, and Authorize Little Rock Cancer Clinic to disclose my information as necessary for treatment, payment and healthcare operations per the Health Information Portability and Accountability Act (HIPAA) guidelines.

_____ _____

Signature of Patient/Legal Representative Date

LITTLE ROCK CANCER CLINIC

Directions:
Doctor's Building – 500 S. University Ave., Suite 811 in Little Rock.
From Interstate 630, take the University Avenue exit and go North. The Doctor's Building is on the west side of University Avenue. (You can see it from the Freeway) You may call our office for further directions at 501-661-1822.



Patient Parking is located on the North side of the Doctor's Building.

Medication List

Patient Name_____ **Chart #**_____

Medications	Dosage
Example: Baby Aspirin	***81mg 1tab ___ /day***

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500 S. University Avenue, Suite 811, Little Rock, Arkansas 72205
501-661-1822 Fax 501-666-0266

Stella Kamanda, M.D., Ph.D.
James F. Beck, M.D.

I agree in order for us to service your account or to collect any amounts you owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended.

I have read this disclosure and agree that "your office or agent" may contact me as described above.

_____
Patient Signature

_____
Date

Cancellation Process/No Show Process

Little Rock Cancer Clinic PA
500 South University Avenue Ste 811
Little Rock, AR 72205

Little Rock Cancer Clinic PA (LRCC) is committed to the delivery of quality care in a professional and caring manner. LRCC is aware there are times appointments are missed due to emergencies or obligations for your employer or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed care.

Effective immediately, after 3 missed appointments (failure to show or call), you may be discharged from care as a direct result of being "noncompliant to treatment."

LRCC will now require cancellations be made at least 24 hours in advance. **Our office will charge $50 for a "No Show Appointment".**

LRCC will also charge $100 for any scheduled outpatient procedure missed without at least a 48-hour notice as well. A "No Show Surgery or Outpatient Procedure" is defined as an outpatient procedure scheduled by staff at LRCC.

Fees must be paid before scheduling another appointment and CAN NOT be billed to insurance.

If cancelled by the physician as a medical necessity, then the patient is not subject to a "no show" charge. Insurance authorization denials are also an exemption of the penalty.

Patient's Signature: Date: