Littleton Radiation and Medical Oncology

5 West Dry Creek Circle
Littleton, CO 80120

Date:_____

Dear _____

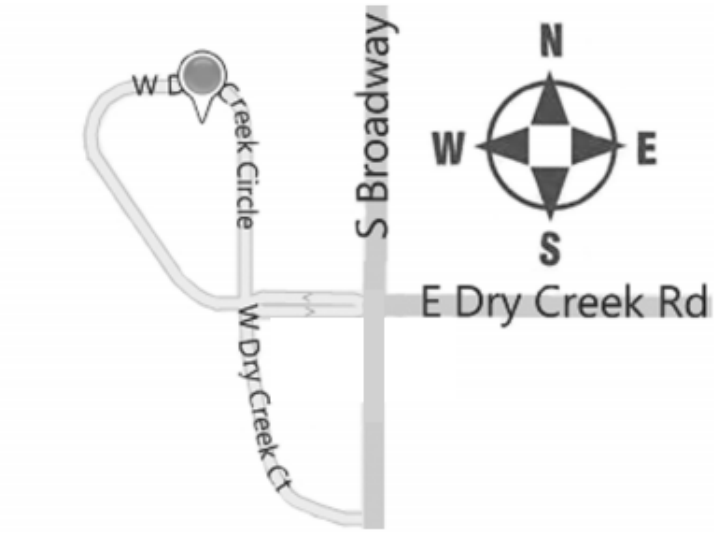
We would like to welcome you to our medical practice. Our records show that you have recently scheduled a consultation with Dr. Schreiber_____, Dr. Tippin_____, or Dr. Schrier_____ on

_____, _____ at _____ a.m. / p.m.

To make your visit to this office pleasant and efficient, we would request that you complete the enclosed forms prior to your appointment. You may fax this completed form at your convenience, bring them to your appointment or mail them in the provided envelope.

It is important that our doctors view any x-rays, scans, or MRI's pertaining to your current diagnosis. We would ask that you obtain any existing films and bring them with you on the day of your appointment.

If there is anything we can do to be of service, please let us know. We look forward to seeing you.



5 West Dry Creek Circle Littleton, CO 80120
Phone 303.738.8700 Fax 303.794.8287

Welcome To Our Office
LITTLETON RADIATION AND MEDICAL ONCOLOGY

Patient Number_____ **Appointment Date**_____

THERE WILL BE A $25 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE
Please print and complete all parts

Language □ **English** □ **Other** _____ **Race** □ **White** □ **Black** □ **Other** _____
□ **Spanish** □ **Asian** □ **Hispanic**

Ethnicity_____**email**_____

Name_____
Last First Middle Initial

Address_____City_____State_____Zip_____

Home_____Cell_____Work_____Date of Birth_____

Age_____Sex_____SSN#_____Employer_____Occupation_____

Spouse_____Employer_____Work Phone_____

Responsible Party: (Person who should receive the bill)

Name_____ Home Phone_____Work_____

Address_____City_____State_____Zip_____

Primary Care Phys_____Phone_____Referring Phys_____Phone_____

Insurance (Please complete. We will need a copy of your insurance card, front and back)

Primary Insurance_____
Address_____
City_____State_____Zip_____
Insured_____
Policy #_____Group #_____
Employer_____
Co-pay $_____

Secondary Insurance_____
Address_____
City_____State_____Zip_____
Insured_____
Policy #_____Group #_____
Employer_____
Co-pay $_____

Notify in case of Emergency (Not living with you)

Name_____**Home Phone**_____**Cell Phone**_____

I authorize payment of medical benefits to physician or supplier for these services and all future claims as well as the release of any medical information necessary to process this claim and all future claims.
I further understand that if my insurance carrier requires a referral for this or any subsequent office visit, and I have failed to obtain such referral, that I will be soley responsible for any charges incurred.
My signature acknowledges my consent allowing my medical records be sent to any physician administering my care.

_____ _____
Signature (Patient or authorized representative) **Date**

LITTLETON RADIATION ONCOLOGY

David P. Schreiber, M.D. **Douglas B. Tippin, M.D., PhD**
David Schrier, M.D.

Name:_____ **Date:**_____

Please circle those that apply

GENERAL	**CHILDHOOD DISEASES**	**G-INTESTINAL**
Unusual fatigue	Measles	Poor appetite
Unusual weakness	Mumps	Hard to swallow
Recent weight loss	Chicken pox	Frequent indigestion
Abnormal thirst	Rubella	Food intolerance
Bruise easily	Diphtheria	Nausea - vomiting
Anemia	Scarlet fever	Yellow jaundice
Swollen nodes	Other	Constipation
Deformity		Take laxatives
Skin rash or sores	**UROLOGY**	Take antacids
Diabetes - gout	Blood in urine	Black stools
Sexual problems	Get up at night	Diarrhea
	Painful urination	Hemorrhoids
HEAD	Slow stream	
Frequent headaches	Urinary frequency	**BONES - JOINTS**
Dizziness	Urinary urgency	Painful joints
Loss of balance	Kidney infections	Persistent backache
Fainting spells	Prostate infections	Feet problems
Head injury	Vasectomy Yes - No	Broken bones
Epilepsy		Muscle weakness
Other	**MENTAL**	Numbness - tingling
	Poor memory	Hard to walk
EYES - EARS	Irritable	Date of last colonoscopy
Glasses	Depressed	
Contact lenses	Emotional stress	**WOMEN**
Visual changes	Nervous breakdown	Breast lump - pain
See double	Other	Vaginal discharge
Hearing loss		Abnormal bleeding
Ringing in ears	**HEART - LUNGS**	Last Pap smear date
Earache	Hard to breathe	Pelvic pain
Other	Persistent cough	Menstrual problems
	Cough with blood	Sexual problems
MOUTH - THROAT	Chest pain	C-Section
False teeth	Asthma	Pregnancies #
Frequent sore throats	High blood pressure	Miscarriages #
Frequent sinusitis	Racing heart	Loss of urine
Hoarseness	Leg cramps	
Speech difficulties	Swollen feet	
Neck swelling	Cold feet	
Thyroid problems	Varicose veins	
Other	Heart murmur	

_____ _____

Patient Signature Date Physician Signature Date

LITTLETON RADIATION AND MEDICAL ONCOLOGY

PATIENT NAME_____ DATE_____

Please list all medications you are currently taking. This includes prescription and over the counter medications.

MEDICATION	STRENGTH (mg)	DOSAGE

Allergies to medications _____

_____

Pharmacy name _____

Pharmacy phone # _____

Pharmacy fax # _____

_____ _____

Signature Date

LITTLETON RADIATION AND MEDICAL ONCOLOGY

David P. Schreiber, M.D. David M. Schrier, M.D. Douglas B. Tippin, M.D., PhD

ADVANCE DIRECTIVE

The purpose of this advance directive is to inform you of a potential and probable personal financial obligation that you may have for the treatment you will be receiving from Littleton Radiation and Medical Oncology. Although these are guidelines, it is your responsibility to know the coverage limits of your insurance.

If you are a patient with:

A. Medicare and no supplement, you would owe 20% of the Medicare allowable (Medicare will pay 80% of their allowable).

B. Any Medicare replacement plan (Medicare Advantage Plans) such as Aetna, Cigna, Anthem, Secure Horizons, Rocky Mountain Health Plan, the portion owed by you may be the same as stated in A (above).

C. For any other insurance plan, please be aware of the percentage that your insurance will pay, as well as the deductible or co-insurance assignment that will result in your personal obligation.

We will help you in every way to estimate the balance you are likely to owe. If necessary, payment arrangements can be made with Lori in our billing office. Please contact her directly at 303.755.2900 x 165 between the hours of 8:00 and 4:00 p.m.

Thank you,

_____ _____

David P. Schreiber, M.D. Date

_____ _____

Patient Signature Date

5 West Dry Creek Circle Littleton, Colorado 80120
Office: 303.738.8700 Fax: 303.794.8287

LITTLETON RADIATION AND MEDICAL ONCOLOGY

5 West Dry Creek Circle
Littleton, CO 80120

REFERRAL POLICY

Your insurance company may require a referral from your primary care physician. If you are not sure of your insurance requirements, please check first with your insurance company.

Due to this insurance regulation, it is necessary for you to acquire any necessary referral prior to your visit. This will help you avoid any additional out-of pocket charges.

Please review and comply with the following:

1. Your referral is required prior to the time of your office visit.
2. We cannot accept verbal referrals. Your primary care physician or insurance company can fax your referral to us 24 hours a day at Littleton Radiation and Medical Oncology 303.794.8287. It is important to tell your primary care physician and/or insurance company the date and time of your appointment.
3. If you do not have a referral, you can be seen for your scheduled visit; however, payment must be made at the time of your visit.
4. Be aware of the expiration date and the number of visits your referral allows. Do not hesitate to ask us to check the remaining number of visits or expiration date at each of your visits.

We hope this information will be helpful during your patient care at Littleton Radiation and Medical Oncology. It is our goal to assist you in understanding and complying with your insurance carrier's requirements. You may have an insurance that does not require a referral at this time. If your insurance changes to a referral based policy, your signature indicates understanding of our policies and the need for a referral. Your signature also confirms your liability for any medical care received without proper referrals from your primary care physician and insurance company.

_____ _____

Patient Signature Date

Littleton Radiation and Medical Oncology

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

Littleton Radiation and Medical Oncology "Practice" is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit this office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also email or mail you a reminder postcard for follow-up visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, Including:

- For public health activities including reporting of certain communicable diseases
- For workers' compensation or similar programs as required by law
- To authorities when we suspect abuse, neglect or domestic violence
- To health oversight agencies

- For certain judicial and administrative proceedings pursuant to an administrative order
- For law enforcement purposes
- To a medical examiner, coroner or funeral director
- For the facilitation or organ, eye or tissue donation if you are an organ donor
- For research purposes under strictly limited circumstances
- To avert a serious threat to your health and safety or that of others
- For governmental purposes such as military service or for national security
- In the event of an emergency or for a disaster relief
- In any other instance required by law

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that action has preceded your revocation. Should you require your records be released, Practice will provide you an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFIY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in our care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communication:** You have the right to request that we communicate with you in a particular manner or a certain location. For example: You may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **Accounting of Disclosures:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have any questions about this notice, please contact Practice's Privacy Officer at 5 West Dry Creek Circle, Littleton, CO 80120 or call 303.738.8700. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have had the opportunity to review the Notice of Privacy Practices for Littleton Radiation and Medical Oncology that outlines how patient confidential information will be used, disclosed and protected.

Printed Patient Name	**Name/Relationship if signed by individual other than Patient**
Patient Signature	**Date**

OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual refused to sign _____ Communication barrier

_____ Care provided was emergent _____ Other

_____
Employee Name Date

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**** PATIENT COPY ****