



Cancer Care

Welcome to HonorHealth Cancer Care. Our valley-wide locations put you, the patient, at the center of everything we do. Our team of specialists are committed to providing you with outstanding coordinated care.

Prior to your visit

Before your appointment, we ask that you print and fill out the attached New Patient Packet. We realize that you may have already provided similar information to other HonorHealth providers in the past and understand that this may seem redundant. However, with health histories and circumstances changing continually, it is important for our team to have your most recent and updated information to provide you with the finest personalized care.

MyChart App

To simplify your healthcare, we strongly encourage you to download or sign up for the MyChart App. MyChart is a free, easy-to-use, secure website that gives you access to your health information quickly and conveniently from your computer, smartphone or tablet. Visit HonorHealth.com/mychart to learn more about the advantages of MyChart and to get instructions on how to sign up.

If you have questions, please do not hesitate to talk to your physician. You may also call 855-485-HOPE (4673) for additional information and support.

It is an honor to serve you during this time.

PATIENT REGISTRATION

Hematology/Medical and GYN Oncology Division

Patient Full Name: _____ Birth Date: _____

SSN: _____ Email Address: _____ Gender: M F

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work phone: _____

Mobile Phone: _____ Mobile Phone Provider: _____

Notification preference? Mobile Phone e-Mail Text Message Home Phone

May we leave a message (circle)? Yes or No Please circle preference for voice message: Home or Mobile Phone

Mothers Maiden Name: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Divorced Widowed

Ethnicity: Hispanic or Latino Not Hispanic or Latino (requested demographic question for the State of AZ)

Race: American Indian or Alaska Native Asian Black or African-American White/Caucasian
 Native Hawaiian Other Pacific Islander Other: _____

Religion Preference: _____

Preferred Language: English Spanish French Chinese Other: _____

Visually Impaired: Yes No

Patient Employer: _____ Occupation: _____

Primary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group#: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group#: _____

Do you have a Living Will? Yes No
Do you have a DNR? Yes No

If yes, please provide a copy for our records
If yes, please provide a copy for our records

Visit Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ When did the problem begin: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE #) _____

PRIMARY DOCTOR (NAME, ADDRESS, PHONE #) _____

PATIENT'S PHARMACY (NAME, ADDRESS, PHONE #) _____

MEDICINE/FOOD/LATEX/CONTRAST ALLERGIES: ___ NONE or LIST IF ANY: _____

CURRENT MEDICATIONS (name and dosage) OR **CHECK HERE** _____ if Med List is attached

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

CHRONIC CONDITIONS/PAST MEDICAL HISTORY: Have you ever had any of the following? (circle all that apply)

- High Blood Pressure
- Diabetes - If yes, type: _____
- Stroke/TIA
- Lupus
- Heart Failure
- Vascular Disease
- Heart Disease
- Heart attack
- Seizures
- Colitis/Diverticulitis
- Anxiety
- Depression

- COPD
- Hyperthyroidism
- Abnormal Heart Rhythm
- Atrial Fibrillation
- Heart Murmur
- Neuropathy
- Hypothyroidism
- Aneurysm
- Blood Clots
- Genetic Disorder Type: _____
- STDs - If yes, type: _____
- HIV
- Other: _____

Have you had any of the following tests?

	<u>Yes</u>	<u>When and Where</u>
Abnormal biopsy	<input type="checkbox"/>	
CT Scan	<input type="checkbox"/>	
MRI Scan	<input type="checkbox"/>	
PET Scan	<input type="checkbox"/>	
Mammogram	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	
PAP Smear	<input type="checkbox"/>	
Endoscopy	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	
Bone Mineral Density Test (DEXA)	<input type="checkbox"/>	

Patient Name: _____ Date of Birth: _____

PATIENT SURGICAL HISTORY (NAME AND YEAR)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Any implanted devices or metal (pacemakers, pumps, etc.) Please circle: YES NO

VACCINES: Have you had the following vaccines:

- | | |
|---|---|
| PNEUMONIA <input type="checkbox"/> NO <input type="checkbox"/> YES, Date _____ | TETANUS <input type="checkbox"/> NO <input type="checkbox"/> YES, Date _____ |
| SHINGLES <input type="checkbox"/> NO <input type="checkbox"/> YES, Date _____ | FLU VACCINE <input type="checkbox"/> NO <input type="checkbox"/> YES, Date _____ |
| OTHER VACCINE <input type="checkbox"/> NO <input type="checkbox"/> YES, Date _____ | |

TOBACCO USE: NEVER CURRENT PREVIOUSLY **ALCOHOL USE:** NEVER CURRENT PREVIOUSLY

CAFFEINE (Coffee, tea, energy drinks) NEVER RARELY DAILY

DRUG USE: NEVER CURRENT PREVIOUSLY **EXPOSURE TO HIV:** NO YES

SOCIAL HISTORY: Lifestyle

Highest Education level: _____

With whom do you live? _____

Do you exercise? Never Sometimes 30 minutes, 3x/week or more

Have you experienced 10 lbs weight loss or gain in past 3 months? NO YES

SOCIAL HISTORY: Mobility

Do you have problems with mobility (use a wheelchair, cane, or walker)? NO YES; if yes describe issue and/or device used: _____

Have you had a fall in the past year? NO YES

Do you feel unsteady? NO YES

FAMILY MEDICAL HISTORY

ALIVE AND WELL?	DISEASE	IF DECEASED, CAUSE AND AGE OF DEATH
FATHER <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
MOTHER <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____

Any history of cancer in the family? _____

Are there any religious considerations that would keep you from receiving blood products? NO YES

Women only ---

Age menstrual cycle began: _____ **Menopause Age:** _____ **Number of Pregnancies:** _____ **Live Births:** _____

CONSTITUTIONAL SYMPTOMS			EYES CONTINUED		
ACTIVITY CHANGE	NO	YES	EYE REDNESS (DRY EYES)	NO	YES
APPETITE CHANGE	NO	YES	FLOATERS	NO	YES
CHILLS	NO	YES	PHOTOPHOBIA (SENSITIVITY TO LIGHT)	NO	YES
DIAPHORESIS (SWEATING)	NO	YES	VISUAL DISTURBANCE	NO	YES
FATIGUE (WEAKNESS)	NO	YES	RESPIRATORY		
FEVER	NO	YES	DYSPNEA ON EXERTION (SHORTNESS OF BREATH ON EXERTION)	NO	YES
NIGHT SWEATS	NO	YES	CHEST TIGHTNESS	NO	YES
PAIN	NO	YES	CHOKING	NO	YES
RIGORS (CHILLS)	NO	YES	COUGH	NO	YES
UNEXPECTED WEIGHT CHANGE	NO	YES	HEMOPTYSIS(COUGHING UP BLOOD)	NO	YES
HEENT			SHORTNESS OF BREATH (DIFFICULTY BREATHING)	NO	YES
CONGESTION	NO	YES	STRIDOR	NO	YES
DENTAL PROBLEM	NO	YES	WHEEZING (ASTHMA)	NO	YES
DRY MOUTH	NO	YES	CARDIOVASCULAR		
EAR PAIN	NO	YES	CHEST PAIN	NO	YES
FACIAL SWELLING	NO	YES	LEG SWELLING	NO	YES
HAIR LOSS	NO	YES	ORTHOPNEA	NO	YES
HEARING LOSS	NO	YES	PALPITATIONS	NO	YES
MOUTH SORES	NO	YES	PND(PAROXYSMAL NOCTURNAL DYSPNEA)	NO	YES
NOSEBLEEDS	NO	YES	GI		
POSTNASAL DRIP	NO	YES	ABDONIMAL DISTENTION	NO	YES
RHINORRHEA (RUNNY NOSE)	NO	YES	ABDOMINAL PAIN	NO	YES
SINUS PRESSURE	NO	YES	ANAL BLEEDING	NO	YES
SORE THROAT	NO	YES	ASCITES (ABDOMINAL SWELLING)	NO	YES
TASTE CHANGES	NO	YES	BLOOD IN STOOL (BLACK STOOLS)	NO	YES
THRUSH	NO	YES	CONSTIPATION	NO	YES
TINNITUS (RINGING IN EARS)	NO	YES	DIARRHEA	NO	YES
TROUBLE SWALLOWING	NO	YES	EARLY SATIETY (FEELING FULL)	NO	YES
VOICE CHANGE	NO	YES	GERD/HEARTBURN	NO	YES
BREAST			NAUSEA AND VOMITING	NO	YES
RIGHT INVERTED NIPPLE	NO	YES	HERNIA	NO	YES
RIGHT MASS	NO	YES	ENDOCRINE		
RIGHT NIPPLE DISCHARGE	NO	YES	COLD INTOLERANCE	NO	YES
RIGHT SKIN CHANGE	NO	YES	DIABETES	NO	YES
LEFT INVERTED NIPPLE	NO	YES	HEAT INTOLERANCE	NO	YES
LEFT MASS	NO	YES	HOT FLASHES	NO	YES
LEFT NIPPLE DISCHARGE	NO	YES	POLYDIPSIA (GREAT THIRST)	NO	YES
LEFT SKIN CHANGE	NO	YES	POLYPHAGIA (EXCESSIVE EATING)	NO	YES
EYES			POLYURIA (EXCESSIVE URINATION)	NO	YES
BLURRED VISION	NO	YES	PRE-DIABETES	NO	YES
DOUBLE VISION	NO	YES	GU		
EYE DISCHARGE	NO	YES	DYSURIA((PAIN/DIFFICULTY URINATING, HESITANCY)	NO	YES
EYE ITCHING	NO	YES			
EYE PAIN	NO	YES	FLANK PAIN	NO	YES

GU CONTINUED			PSYCHIATRIC		
FREQUENT URINATION	NO	YES	AGITATION	NO	YES
HEMATURIA (BLOOD IN URINE)	NO	YES	BEHAVIOR PROBLEM	NO	YES
INCONTINENCE	NO	YES	CONFUSION	NO	YES
NOCTURIA (FREQUENT URINATION AT NIGHT)	NO	YES	DECREASED CONCENTRATION	NO	YES
PENILE DISCHARGE	NO	YES	DEPRESSION	NO	YES
PENILE PAIN	NO	YES	HALLUCINATIONS	NO	YES
PENILE SWELLING	NO	YES	HYPERACTIVE	NO	YES
SCROTAL SWELLING	NO	YES	NERVOUS/ANXIOUS (PANIC ATTACKS)	NO	YES
TESTICULAR PAIN	NO	YES	SELF-INJURY	NO	YES
URGENCY TO URINATE	NO	YES	SLEEP DISTURBANCE (INSOMNIA)	NO	YES
DECREASED URINE	NO	YES	SUICIDAL IDEAS	NO	YES
MUSCULOSKELETAL			HOMICIDAL IDEAS	NO	YES
ARTHRALGIAS (JOINT PAIN/BONE PAIN)	NO	YES	GYN		
BACK PAIN	NO	YES	VAGINAL DISCHARGE	NO	YES
GAIT PROBLEM (WALKING ABNORMALLY)	NO	YES	VAGINAL PAIN	NO	YES
JOINT SWELLING	NO	YES	ABNORMAL BLEEDING	NO	YES
MYALGIAS (MUSCLE PAIN)	NO	YES			
NECK PAIN	NO	YES			
NECK STIFFNESS	NO	YES			
SKIN					
BLISTERING	NO	YES			
CHANGING MOLES (SKIN LESIONS)	NO	YES			
COLOR CHANGE	NO	YES			
ALLERGY/IMMUNE SYSTEM					
ENVIRONMENTAL/SEASONAL ALLERGIES	NO	YES			
FOOD ALLERGIES	NO	YES			
IMMUNOCOMPROMISED	NO	YES			
CHEMICALS IN WORKPLACE	NO	YES			
NEUROLOGICAL					
PAINFUL NEUROPATHY	NO	YES			
DIZZINESS	NO	YES			
FACIAL ASYMMETRY	NO	YES			
HEADACHES	NO	YES			
LIGHT-HEADEDNESS	NO	YES			
NUMBNESS/TINGLING	NO	YES			
SEIZURES	NO	YES			
SPEECH DIFFICULTY	NO	YES			
SYNCOPE (ALTERED CONSCIOUSNESS)	NO	YES			
TREMORS	NO	YES			
WEAKNESS (PARALYSIS)	NO	YES			
HEMATOLOGIC					
ADENOPATHY (ENLARGED GLANDS)	NO	YES			
BRUISES/BLEEDS EASILY	NO	YES			
LYMPHEDEMA	NO	YES			
PETECHIAE (BLEEDING UNDER SKIN)	NO	YES			
PURPURA (RASH)	NO	YES			

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Healthcare Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE BREAST CANCER	45	—	—	Aunt Cousin	45 51	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE (ENDOMETRIAL) CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME GASTROINTESTINAL POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	<i>Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid</i>						

- Y N Are you of Ashkenazi Jewish descent?
 Y N Are you concerned about your personal and/or family history of cancer?
 Y N Have you or anyone in your family had generic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any of the following:

<input type="checkbox"/>	Multiple A combination of cancers on the same side of the family:	<input type="checkbox"/> 2 or more: breast / ovarian / prostate / pancreatic cancer <input type="checkbox"/> 2 or more: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) <input type="checkbox"/> 2 or more: melanoma / pancreatic
<input type="checkbox"/>	Young Any 1 of the following at age 50 or younger :	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Endometrial cancer
<input type="checkbox"/>	Rare Any 1 of these rare presentations at any age :	<input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Breast: Male breast cancer or Triple negative breast cancer <input type="checkbox"/> Colorectal cancer with abnormal MSI/IHC, or MSI associated <u>histology</u> ++ <input type="checkbox"/> Endometrial cancer with abnormal MSI/IHC <input type="checkbox"/> 10 or more gastrointestinal polyps*

* Presence of tumor infiltrating lymphocytes, Chrohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern * Adenomatous type
 Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use only: Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Next Appointment _____



Hospital Outpatient Clinic Based Locations

When you receive services in one of our hospital outpatient clinic based locations, you will receive two separate charges from HonorHealth. Your billing statement will show clinic outpatient visit or a telehealth visit charge under the **Facility Services** section of your statement. You will also receive a separate charge for the **Professional Services**, which will show with the performing physician's or clinical professional's name. The statement of charges will show services in two categories as noted below:

- **Facility Services:** Covers the overhead for the facility including nursing, registration, equipment, supplies, building, etc. The clinic outpatient or telehealth visit charge will be shown here.
- **Physician and Clinical Professionals:** Covers your doctor's services, treatment or procedures performed, and does not include any costs for overhead.

The facility charge is the result of HonorHealth's physician offices and outpatient clinics being classified as hospital outpatient departments, also called provider-based facilities.

Provider-based billing applies to all patients, regardless of the type of insurance you have. The way your insurance covers these charges may be different, based on whether you have insurance through your employer, other insurance company or if you are covered by Medicare.

How this affects you if you are covered by your employer health plan or other insurance (not Medicare): The way your insurance company handles these charges will vary based on your health plan. Some insurance companies may apply these charges to your annual deductible, coinsurance or co-pays. To find out what will be covered, contact your insurance company. If you have additional questions, please contact one of our financial counselors.

How this affects you if you have Medicare:

- The **Facility Services** charge(s) will be billed to Medicare Part A.
- The **Physician And Clinical Professionals** charge will be billed to Medicare Part B

You will receive two Medicare Summary Notices (MSNs, one for Part A and one for Part B):

- If you have secondary insurance, we will submit any balance to that insurance company.
- If your secondary insurance does not cover the remaining balance or if you do not have secondary insurance, the balance will be billed to you.



Cancer Care

Infusion Financial Counselor introduction

At HonorHealth, the last thing we want is for your care to be frustrating. One of the ways we go beyond in caring for you is by meeting with you before you begin treatment. We'll discuss costs and options that can help alleviate any unexpected financial burden of your treatment. Our financial counselors will provide you with financial information regarding your insurance benefits (including details about your deductible status and out of pocket liability), as well as our payment policies. Determining your financial needs is not a one-time exercise –our financial counselors will meet with you and your family regularly to update any changes in your insurance coverage and reevaluate your financial resources throughout your treatment plan. Since you'll be receiving infusion treatments or injections in one of our clinics, here's how our team will support you:

- Once treatment is prescribed, our authorization team will verify the authorization requirements for your insurance. Our team members will initiate the authorization process to ensure your treatment can start in a timely manner.
- Our financial counselors will reach out to you before you start treatment to explain your insurance coverage, review your benefits and discuss your estimated financial responsibility based on information provided by your insurance.
- Once your authorization has been received, our team will continue to follow your treatment to ensure that any ongoing authorization needs are addressed.
- Our financial counselors will also review any possible financial assistance options from the manufacturer (if applicable), third-party foundations and any programs available through HonorHealth.
- If your physician orders a treatment that your insurance does not authorize, we'll work with the pharmaceutical company to apply for any applicable assistance program for you. Our counselors will work with you to complete the financial assistance forms and submit them for you.

Financial counselors are available from 7:30 a.m. to 3:30 p.m., Monday-Friday to answer your questions and discuss your treatment plan.

Thank you for choosing HonorHealth. We look forward to going the extra mile for you.

Laura Luna

Manager-Patient Access
Laluna@honorhealth.com

Haily Radell

Supervisor-HOPD
PH. 602-562-3453
hradell@honorhealth.com

Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends with whom HonorHealth Cancer Care can share your protected health information.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I _____ acknowledge that I have received a copy of HonorHealth Cancer Care's Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Cancer Care Cancer Care Network.

I understand that this release is valid for the time frame of my diagnosis but may revoke authorization at any time by informing HonorHealth Cancer Care specialists and my physician.

Print Name: _____

Date: _____

Patient Signature: _____

Medical Records Release To:

HonorHealth Cancer Care
2500 W. Utopia Road, Phoenix AZ 85027

I authorize the following physician/facility to disclose information from my health record:

Physician Name _____ Facility: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

PATIENT IDENTIFICATION <i>All information must be filled out completely to process your request</i>	Patient Name _____		Date of Birth _____
	Address _____ City _____ State _____ Zip _____		Phone Number _____
Dates of Service: From _____ To _____			
INFORMATION REQUESTED	<input type="checkbox"/> Office Visit Note(s) <input type="checkbox"/> Laboratory Results <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record	<input type="checkbox"/> Other:
INFORMATION TO BE SENT TO	HonorHealth Cancer Care Email: hhcancercarechartprep@honorhealth.com Phone: 602-562-3445 Fax: 480-882-5015		

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The John C. Lincoln Physician Network Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I may receive a copy of this authorization.

Unless I revoke this authorization earlier, **it will expire one year from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: _____ Date Sent: _____ Processor: _____

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