



GAMMA WEST

CANCER SERVICES

Name _____
 First Middle Last

Address _____
 Street City State Zip

Date of birth _____ SSN _____

Home Phone _____ Cell Phone _____

Email address _____

Occupation _____ Work Phone _____

Employer _____

Employer address _____

Status: Full time Part time Retired/Date retired _____

Sex: Male Female

Ethnic Origin: Caucasian African American Hispanic Asian Native American

Marital Status: Single Married Divorced Widow/Widower

Spouse's Name _____

Date of birth _____ SSN _____

Employer _____ Work Phone _____

Nearest Relative Not at Your Address _____

Relationship to Patient _____ Home Phone _____

Address _____

Referring Physician _____

Primary Care Physician _____

Insurance Information

Is Medicare your primary insurance? Yes No

Medicaid # _____ Effective Date _____

Primary Insurance Information

Insurance _____

Subscriber _____

Relationship _____ Policy# _____ Group# _____

Secondary Insurance Information

Insurance _____

Subscriber _____

Relationship _____ Policy# _____ Group # _____

I authorize GammaWest Cancer Services to bill my insurance company for charges incurred during the course of my treatment and to provide any medical information necessary to process this claim. I authorize payment to be made directly to GammaWest Cancer Services, and a copy of this authorization may be used instead of the original. I authorize GammaWest Cancer Services to inquire about my accounts and to receive any information about any and all of my Medicare, Blue Shield or other insurance claims, assigned or non-assigned and I understand that I am fully responsible for charges incurred with this treatment even though the doctor files my insurance for me. I understand that if my account becomes delinquent, it may be subject to collection fees, attorney fees, court costs and interest and I acknowledge responsibility.

Patient Signature Date

Guarantor's Signature (if other than patient) Date



GAMMA WEST **CANCER SERVICES**

CONSENT TO RELEASE OF MEDICAL INFORMATION

Name of Patient _____ Date of Birth: _____

Social Security ____ - ____ - ____

INFORMATION TO BE RELEASED:

Radiology reports Pathology reports Lab reports Clinical reports

I request the above information to be released FROM:

Name: _____

Address: _____

and released TO:

Name: GammaWest Cancer Services – Phone: 801-350-8400 Fax: 350-4021

Address: 1050 East South Temple, Salt Lake City, UT 84102

RELEASE OF INFORMATION FROM GAMMAWEST CANCER SERVICES MUST COMPLY WITH THE GOVERNMENT RECORDS AND MANAGEMENT ACT (GRAMA). ACCESS TO THESE RECORDS IS LIMITED. BEFORE WE RELEASE THE RECORD WE ARE REQUIRED BY GRAMA TO OBTAIN EVIDENCE OF THE REQUESTER'S IDENTITY. PLEASE COME INTO OUR OFFICE AND PRESENT IDENTIFICATION OR COMPLETE THE AFFIDAVIT BELOW AND RETURN IT TO US.

AFFIDAVIT

I have read the above statement and understand that access to the records I have requested is restricted and that there are criminal penalties for obtaining record by false pretenses. I am entitled to authorize the release of this information because:

- I am the subject of the record
- I am the person who provided the information
- I am authorized to have access by the subject of the record by the person who submitted the information and I have attached the required documentation.

Print Name: _____

Signature: _____ Date: _____

Information For Your Physician

Referring Physicians Name: _____

Address, City, State and Zip Code: _____

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Current Age: _____ Place of Birth: _____

Height: _____ Weight: _____

Race or nationality of parents: _____

Are you employed? Yes No Retired

If yes, what is your occupation? _____

Have you traveled outside the USA and Canada in the past 5 years? Yes No

If yes, where? _____

	Living		Present age or age at death	Significant health problems or cause of death
Father	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Mother	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Spouse/Domestic Partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Present marriage/relationship (yrs) _____

Previous marriage(s)/relationship(s) yrs) _____

Name of spouse _____

	Number Living	Number Non-Living	Significant Health Problems	Cause(s) of death
Brothers				
Sisters				
Children				
Grandchildren				

Please check illnesses which have occurred in any of your blood relatives:

- Kidney disease Diabetes High blood pressure Nervous disease
 Cancer Heart disease Bleeding tendencies Stroke

Please check illnesses or conditions which you have had:

- Asthma Cancer Bleeding tendencies Diabetes
 Glaucoma HIV Heart trouble Hepatitis
 Kidney disease Jaundice High blood pressure Nervous disorder
 Pneumonia Stroke/TIA Rheumatic fever Tuberculosis
 Hypothyroidism Sleep apnea Reflux/peptic ulcer disease
 Blood clots Obesity Elevated cholesterol
 TURP Other: _____

Have you ever had radiation therapy for chemotherapy? No Yes

If yes, please explain _____

What type of physical activities do you perform (including Yoga, Tai Chi, etc.)?

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)? _____

Previous operations (please list procedure and year):

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

Have you ever had any serious injuries, broken bones, etc? Yes No
 If yes, please list: _____

Have you ever had an allergic reaction to X-ray contrast dye? Yes No
 If yes, please describe: _____

Have you every had a latex allergy? Yes No

Have you ever had a tape allergy? Yes No

	Never	Now	In the past	How much each day?	For how many years?	When did you quit?
Tobacco Use						
Alcohol Use						
Recreational drug use						

Please check the disease against which you have immunized:

- | | | | |
|----------------------------------|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pneumoccal Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> German measles (Rubella) | <input type="checkbox"/> Influenza |

Prescription Medications	Dosage (mg)	Frequency (once, twice, etc., per day)

Have you ever had an allergic reaction to any medication? Yes No
 If yes, which medication and what type of reaction:

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

 Patient Name

 Date

INTERNATIONAL PROSTATE SYMPTOM SCORE
(Circle one number on each line)

Name _____

Date _____

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 (None)	1 (1 time)	2 (2 times)	3 (3 times)	4 (4 times)	5 (5 times or more)

Sum of 7 circled numbers (IPSS SCORE): _____

URINARY BOTHER SCORE

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Do you have a tremor? (please circle one) **YES NO**

If yes, is it due to one of the following? (please circle one)

Parkinson's Disease? **YES NO**

Stroke? **YES NO**

Familial? **YES NO**

Other? **YES NO**

If you circled yes to other, please provide explanation for tremor.



Notice of Privacy Practices

Effective Date: April 14, 2003

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.

As a patient of GammaWest Cancer Services, each time you contact our office a record is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care of treatment, and billing-related information. This notice explains how we may use and disclose your health information. This information is called "protected health information", or "PHI". This notice describes your rights as a patient with the terms of our Notice of Privacy Practices.

Our Responsibilities

We are required by law to maintain the privacy of your PHI and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures (How we may use and disclose medical information about you.)

The following categories describe the different ways we may use and disclose medical information. The examples included in this description do not list every use or disclosure related to that category.

- **For Treatment:** We may use health information about you to provide treatment or services. We may disclose PHI about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you during your treatment at GammaWest Cancer Services, the providing hospital and their staff. Different departments of the hospital also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays. We may also provide your physician or subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from GammaWest Cancer Services and the providing hospital.
- **For Payment:** We may use and disclose your PHI to bill and collect payment for healthcare services provided to you. We may also share information with your health plan before services are rendered. For example, we may verify that a certain service will be covered by your health plan before the service is performed. We may also send information to your health plan to confirm services rendered. PHI may also be used and disclosed for billing, claims management, and for collection services.

- **For Health Care Operations:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcome in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. Or, we may combine medical information we have with that of other doctors and hospitals to see where we can make improvements.

We May Also Use and Disclose Health Information:

- To business associates we have contracted with to perform the agreed service and billing for it.
- To remind you that you have an appointment for medical care.
- To assess your satisfaction with our services.
- To tell you about possible treatment alternatives.
- For population based activities related to improving health or reducing health care costs.
- For conducting training programs or reviewing competence of health care professionals.
- For research purposes.

When disclosing information, primarily appointment reminders, treatment schedules and billing/collection efforts, we may leave messages on your answering machine/voice mail.

Other Uses and Disclosures We Can Make Without Your Written Authorization:

We may use and disclose PHI about you in some circumstances where you have the right to agree or to object the certain uses of your PHI. We may use and disclose your PHI without obtaining authorization in the following situations, provided that we comply with certain conditions that may apply.

- **Notification of Family and Close Friends:** We may use or disclose PHI about you to notify a family member, close friend, personal representative, or another person responsible for your care. If you are present and able to consent or object, then we may only use or disclose this information if you do not object. If you are unable to consent or object, we may exercise professional judgment to disclose PHI as necessary if we determine it is in your best interest.
- **Business Associates:** There are some services provided by our organization through contracts with business associates. Examples include physician services in the operating room, radiology, certain laboratory tests, and hospital dictation service. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Required By Law:** We may use or disclose your PHI to the extent that we are required by federal, state, or local law to do so. Any disclosure will fully comply, and be limited to the requirements of the law.
- **Public Health Activities:** We may use and disclose PHI to public health authorities that are authorized to receive or collect information related to public health. We may use or disclose your information for the following activities:
 - To prevent or control disease, injury, or disability.
 - To report a disease, injury, or death.
 - To report child abuse or neglect.

- To report reactions to medications or problems with products regulated by the FDA.
 - To locate and notify persons of product recalls on products they may be using.
 - To notify a person who may have been exposed to a communicable disease to prevent spreading.
 - To report to you employer, under limited circumstances, information related to workplace injuries.
- **Abuse, Neglect, or Domestic Violence:** We may use or disclose PHI about a patient whom we reasonably believe has been the victim of abuse, neglect, or domestic violence. Such disclosures will be made to government authorities that are authorized by law to receive reports of such incidents. All reports will be made in accordance to the requirements and limitations of the law.
 - **Health Oversight Activities:** We may use and disclose PHI in health oversight activities such as audits, investigations, inspections, licensures, disciplinary actions, and other activities conducted by health oversight agencies to monitor health care.
 - **Law Enforcement:** We may use and disclose PHI to law enforcement officials in compliance with and limited to the requirements of the law. Some examples of information given to law enforcement are a suspected crime victim, in response to a court order or subpoena, to identify or locate a suspect or fugitive, or in response to a medical emergency related to a crime..
 - **Organ and Tissue Donation:** If you are an organ donor, we may disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation or transplantation.
 - **Coroners, Medical Examiners, Funeral Directors:** We may use or disclose your PHI to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also disclose PHI to funeral in accordance with the law to help them perform their jobs.
 - **Research:** We may use and disclose PHI about you for research under limited circumstances. We may use or disclose your information when the research project meets specific detailed criteria that protect the privacy of your PHI.
 - **Judicial and Administrative Proceedings:** We may use and disclose your PHI in the course of any judicial or administrative hearing in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process where we receive satisfactory assurance that appropriate precautions have been taken. In all cases, we will take reasonable steps to protect the confidentiality of your PHI.
 - **To Avert a Serious Threat to Health or Safety:** We may use or disclose your PHI to avert a threat to the health and safety of the public or to an individual. This disclosure can only be made to persons authorized to help prevent the threat.
 - **Specialized Government Functions:** We may use and disclose your PHI to certain government agencies charged with special government functions as applicable by law. For example, we may disclose PHI to government officials for intelligence or national security activities as applicable by law.
 - **Workers Compensation:** We may use and disclose your PHI as authorized by workers' compensation laws.
 - **Marketing:** For marketing activities, we will obtain your written authorization prior to sending any information to you, unless we are not required by law to do so.

Other Uses and Disclosures of Protected Health Information Require Your Authorization:

All other uses and disclosures of PHI about you will only be made with a written authorization from you. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent that the action has already been taken based on the written authorization.

Your Rights Regarding Your Protected Health Information:

Under Federal law, you have the following rights regarding your PHI.

- **Right to Request Restrictions:** You have the right to request that we place additional restrictions on the use and disclose of your PHI in treatment, payment, or operations. You may also request additional restrictions on the disclosure of your PHI to certain individuals. Such requests must be made in writing, must tell how you want to restrict the information, and must tell whom you want these restrictions to apply. While we will consider any request for additional restrictions, we are not required to agree to your request. Please direct any requests to our Privacy Official.
- **Right to Receive Confidential Communications:** You have the right to request to receive your health information at alternative locations or by alternative forms of communication. All requests must be made in writing and directed to our Privacy Official. We are required to accommodate *reasonable* requests.
- **Right to Inspect and Copy:** You have the right to request the opportunity to inspect and receive a copy of PHI in certain records that we maintain. This includes your billing and medical records, but does not include psychotherapy notes or information gathered for civil, criminal, or administrative proceedings. To inspect and copy PHI please contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request.
- **Right to Amend:** You have the right to request that we amend PHI about you as long as our office keeps such information. To make this request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or you do not give us a reason for the request.
- **Right to Receive an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures that we have made of you PHI. This is a list of disclosures made by us during a specified period of up to six years. This does not have to include disclosures made for treatment, payment, and operations, for use in our facility, for information given to family members involved in your care, to information given directly to you, or for any disclosures made before April 14, 2003. For each disclosure, the accounting will include the date the information was disclosed, to whom, the address of the person or entity that received the disclosure, and a brief statement of the reason for disclosure. All requests must be in writing and directed to our Privacy Official.
- **Right to Receive a Paper Copy of this Notice:** Upon request, you have a right to receive a paper copy of this Notice. At the time you are presented this Notice, you will have the opportunity to request your own copy of this Notice. You may come to the office at anytime to receive a copy.
- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the United State

Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Official at the number and address listed below. You will not be penalized for filing a complaint.

Changes to this Notice:

We reserve the right to changes to this Notice and make such changes effective for all PHI we may already have about you. If and when this Notice is changed, a current notice will be posted at GammaWest Cancer Services. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

Questions:

If you have questions about this Notice, please contact our Privacy Official at the address and telephone number listed below.

Privacy Official Contact Information:

You may contact our Privacy Official at the following address and phone number.

GammaWest Cancer Services
Attn: Privacy Official
425 E 5350 South, Ste 180
Ogden, UT 84405

Phone:	(801) 475-4571 – Ogden	FAX – (801) 415-6119
	(801) 350-8400 – SLC	FAX – (801) 350-4021



Patient Name: _____

DOB: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the GammaWest Cancer Services Notice of Privacy Practices. I understand that if I have questions or concerns, I may contact the Facility Privacy Official.

Patient Initials

DISCLOSURE OF FINANCIAL INTEREST

Because of concerns there may be conflict of interest when a physician refers a patient to a healthcare facility for other treatment in which the physician has a financial interest, the State of Utah passed a law. The law requires that I disclose this financial interest to you and provide and state that you may choose any facility or service center for the purpose of having this treatment performed. This disclosure is intended to help you make a fully informed decision about your health.

For more information about alternative providers, please ask me or my staff.

The physicians at GammaWest Cancer Services or their family member(s) have a financial interest in GammaWest which provides brachytherapy service.

ACKNOWLEDGMENT

I have read and understand the above notice.

Patient Signature

Date

Directions to GammaWest Cancer Services

Salt Lake City Clinic

Our Salt Lake City, Utah *GammaWest Cancer Services* clinic is located at 1050 East South Temple within the IASIS-Salt Lake Regional Medical Center. Our telephone number is (801) 350-8400.

Coming from I-15 North take the 600 North exit and proceed East to 400 West. Make a right at 400 West and come up to South Temple. Turn left on South Temple and come up to 1000 East and turn right. Go down about ½ a block to the hospital Emergency Entrance on your left. Enter the driveway and proceed east to the underground parking. Proceed to the hospital entrance on the ground floor, next to the Emergency room entrance, and walk to your right where you will see the *GammaWest Cancer Services* sign across from the hospital admitting desks.

Coming from I-15 South take the 600 South exit and proceed East to 700 East. Make a left at 700 East and come up to 100 South. Turn right on 100 South and come up to 1000 East and turn left. Go down about ½ a block to the hospital Emergency Entrance on your right. Enter the driveway and proceed east to the underground parking. Proceed to the hospital entrance on the ground floor, next to the Emergency room entrance, and walk to your right where you will see the *GammaWest Cancer Services* sign across from the hospital admitting desks.

Orem Clinic

GammaWest Cancer Services clinic is located at 674 West 800 north, suite B-10, in the Medical Plaza of the Timpanogas Hospital.

From I-15 proceed east on 800 north in Orem. Turn left at 800 West. Turn into the first hospital entrance and proceed to the Medical Plaza located on the southeast corner. We are located on the basement floor is Suite B-10.

From State Street in Orem you would proceed West. Turn right at 800 West into the Timpanogas Hospital entrance and proceed to the Medical Plaza located on the southeast corner of the hospital.

Ogden Clinic

Our Ogden, Utah *GammaWest Cancer Services* clinic is located at 425 East 5350 South. Our telephone number is (801) 475-4571.

If you are traveling on I-15 (north or south) take exit 341 (31st Street, east bound). Proceed east on 31st street to Washington Boulevard. Turn right (south) onto Washington Boulevard. As you drive south on Washington you will notice that the road heads up the hill and turns to the east. Turn right (south) onto Adams Avenue and continue south approximately 2 blocks. Turn right at the first stop light, 5350 S. (St. Benedict Way), and turn left at the second driveway into the Ogden Medical Plaza. Enter in the main (north) entrance. Take the first hallway on your right and we are located in Suite 180, the last door on your left.

If you are traveling west on Highway I-84, after going through Weber Canyon, exit onto Highway 89 heading north towards Ogden. The road heads up the hill into Ogden and eventually turns into Washington Boulevard. Turn left (south) onto Adams Avenue and continue south approximately 2 blocks. Turn right at the first stop light, 5350 S (St. Benedicts Ways), and turn left at the second driveway into the Ogden Medical Plaza. Enter the main (north) entrance. Take the first hallway on your right and we are located in Suite 180, the last door on your left.