MOUNTAIN BLUE
CANCER CARE CENTER

Today's Date: _____

Last Name:_____First Name:_____MI: _____ DOB:_____

Primary Care Physician:_____Phone:_____

Who referred you here: _____Phone:_____

Pharmacy:_____Cross Streets: _____City:_____

Any known ALLERGIES: NO YES If yes please list below

Allergy (drug name)	Reaction:	Please circle one below:
		mild, moderate, severe
		mild, moderate, severe
		mild, moderate, severe
		mild, moderate, severe
		mild, moderate, severe

List all medication currently taking:

	Medication name	Strength	Directions	Reason for taking
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

Name:_____ DOB:_____

Please list any surgeries within the last five years:

Surgery	Date	Location
1._____	_____	_____
2._____	_____	_____
3. _____	_____	_____

Personal Cancer History

Type of Cancer	Date Diagnosed	Treatment Length/Dates
1._____	_____	_____
2. _____	_____	_____

Family Cancer History

Relative	Age of Diagnosis	Disease	Living/ Current Age	Cause of Death/Age
Mother	_____	_____	_____/_____	_____/____
Father	_____	_____	_____/_____	_____/____
Sibling	_____	_____	_____/_____	_____/____
Sibling	_____	_____	_____/_____	_____/____
_____	_____	_____	_____/_____	_____/____

Other Medical Conditions

Condition	Treating Physician
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Name:_____ DOB:_____

Social History

Marital Status (circle one): Single Married Widowed Divorced Separated Significant Other

Lifetime Occupation:_____

Work Status: Working Retired Disabled

Advanced Directives (circle all that apply): Living Will Power of Attorney DNR

Do you currently drink? YES NO If yes, how much: _____
Any illicit drug use? YES NO If yes please specify: _____
Do you currently smoke? YES NO If yes, packs per day: _____
Have you ever smoked? YES NO *If yes, and you no longer smoke, answer the following*:
How long did you smoke? _____ years how many packs per day: ___Year Discontinued:_____
Any HIV risk? YES NO If yes please specify:_____

For Women Only:

Date of last menstrual period:_____ Age of first menstrual period:_____
Are you still having periods: _____ Are they regular:_____ Length of cycle:_____

Date of Last PAP: _____ ☐ Normal ☐ Abnormal

Date of last Mammogram:_____☐ Normal ☐ Abnormal

Date of last Breast Exam:_____ ☐ Normal ☐ Abnormal Frequency of Self Exams:_____

Number of Pregnancies:_____ Age at first Pregnancy:_____Number of live Child Births:_

Age at first Child Birth:_____ Number of Miscarriages:_____Number of Stillborns:_____

Contraceptives & Hormone Replacement:

☐ Currently taking a Contraceptive – Name:_____Length of Usage: _____

☐ Taken a Contraceptive in the past – Name:_____Dates of Usage: _____

☐ Currently taking Hormone Replacement – Name:_____Length of Usage: _____

For Men Only:

Date of last Prostate Exam:_____ ☐ Normal ☐ Abnormal

Recent PSA results: _____ Date: _____
Prior PSA results: _____ Date: _____

Name:_____ DOB:_____

Constitutional:
YES NO Weight loss: how many pounds
YES NO Night Sweats
YES NO Itching
YES NO Fatigue

Eyes:
YES NO Double Vision
YES NO Cataracts, if yes, Right or Left: _____

Lung:
YES NO Asthma/ Emphysema
YES NO Shortness of Breath
YES NO Cough
YES NO Tuberculosis (TB)
YES NO Pneumonia

Heart:
YES NO Heart Murmurs
YES NO Ankle Swelling
YES NO Congestive Heart Failure
YES NO Heart Attacks, if yes, when: _____
YES NO Pacemaker
YES NO Chest Pain
YES NO Rapid Heart Beat

Gastrointestinal:
YES NO Heartburn/ stomach pain/discomfort
YES NO Nausea/vomiting
YES NO Hiatal hernia
YES NO Diarrhea if yes how often: _____
YES NO Constipation, how long: _____
YES NO Bloody Stools
YES NO Gallbladder problems
YES NO Liver problems
YES NO Pancreas Problems
YES NO Colitis
YES NO Jaundice

Genitourinary:
YES NO Urine Frequency
YES NO Infections
YES NO Blood in Urine
YES NO History of Stones
YES NO Painful Urination

Lymph:
YES NO Swelling of Glands

Musculosketal:
YES NO Difficulty Walking
YES NO Joint Aches/Stiffness
YES NO Painful Legs or Feet
YES NO Back Pain
YES NO Muscle Pain
YES NO Joint Swelling
YES NO Broken Bones
YES NO Arthritis, if yes, what type: _____

Skin:
YES NO Sores/Rashes
YES NO Ulcers
YES NO Psoriasis
YES NO Eczema

Neurological:
YES NO Headache
YES NO Dizziness
YES NO Numbness
YES NO Seizures/Convulsions
YES NO Memory Changes
YES NO Speech Changes
YES NO Strokes
YES NO Dementia

Psychosocial:
YES NO Nightmares /Hallucinations
YES NO Depression
YES NO Anxiety/Nervousness

Endocrine:
YES NO Cold Intolerance/Heat intolerance
YES NO Excessive Thirst
YES NO Thyroid Disease

Hematology:
YES NO Anemia
YES NO Easy Bruising
YES NO Prolonged Bleeding
YES NO Blood Clotting Problems
YES NO Blood Transfusions if yes, when: ____

Immunologic/Allergies:
YES NO Swelling of Eyes/Eyelids
YES NO Hives
YES NO Sinus Problems
YES NO Hay Fever

MOUNTAIN BLUE
CANCER CARE CENTER

PATIENT: _____ _____ _____
Last Name First Name Middle Initial
Date of Birth: _____ Sex: F M ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____Cell Phone: _____
Email (for patient portal): _____ Social Security number: _____-_____-_____
Emergency Contact: _____ Phone: _____Relationship:_____
Address:_____
****

Insurance: (Please provide copy of insurance card(s)

Primary Insurance: _____
ID #: _____Group: _____

Secondary Insurance: _____
ID #: _____Group: _____

Prescription Drug Coverage: _____
ID #_____ Group #_____
PCN_____ Bin_____

Advanced Directives (check all that you have in place)
__DNR __ Living Will __Power of Attorney

****

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____
****

Please list whom we may talk to about your medical condition and/or billing issue: Mark all that apply:
Name: _____Relationship: _____Phone:_____ ( )medical ( )billing
Name: _____Relationship: _____Phone:_____ ( )medical ( )billing
Name: _____Relationship: _____Phone:_____ ( )medical ( )billing

(a) I authorize payment of medical benefits to the physician for procedures, testing, medical supplies and rentals for the services rendered and all future claims. I herby authorize Assignment of Benefits to Mountain Blue Cancer Care Center. In the event my insurance carrier does not accept Assignment of Benefits and payment is made to my representative or me, I will endorse such payments to Mountain Blue Cancer Care Center
(b) I understand I am fully responsible for all charges not covered by the above insurance carrier(s)
(c) I understand I have the right to request and receive a Notice of Privacy Practice "HIPAA" from MBCCC
(d) I authorize my insurance carrier, hospital, treatment center, and previous physicians to release any pertinent information regarding my health care to Mountain Blue Cancer Care Center

Patient signature: _____ Date: _____
By signing you acknowledge and understand the above information, give permission to discuss issues with the above listed and all information provided is accurate to the best of your knowledge

A more personalized, supportive and precise approach to cancer care.

799 E. Hampden Ave., Suite 500 • Englewood, CO 80113
Phone: 303.953.7400 • Fax: 303.953.7401

NOTICE OF PRIVACY PRACTICES

Revised 5/24/2019

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND THE RIGHTS YOU HAVE PERTAIN YOUR HEALTH INFORMATION.

About us

In this notice, we use terms like "we", "us", "our", which refers to Mountain Blue Cancer Care Center, the physician and employees.

Purpose of this Notice

This notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of services we provide you and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of legal duties and privacy practices with respect to your health information. We will abide by the terms of this notice

How we may Use or disclose our Health Information

The following categories describe examples of the way we use and disclose your health information.

For Treatment:

We may use your health information to provide you with medical treatment or services. We may also disclose your health information to other treating physicians or other health care providers to ensure they have all information needed for purpose of consultation and or to diagnose and treat you.

For Payment:

We may disclose your health information to insurance companies in order for us to be reimbursed for services rendered. We may also share your information with pharmaceutical companies for patient assistance programs in order to assist you in obtaining payment for your care.

For Health Care Operations:

We may use and disclose your health information in order to support our business activities such as training of medical students, necessary credentialing and other essential activities. We will have you sign in at the front desk and we may call your name in the waiting room for your appointment. We may disclose your information to a third party that performs services such as billing and collections. All parties will enter into a written agreement to ensure your health information is protected.

Appointment Reminders:

We may use and disclose your health information in order to contact you to remind you of an upcoming appointment for treatment.

Health Related Services:

We may disclose your health information to inform you of programs or services we believe would benefit you. We may do so by calling, sending information in the mail or sending you an email (if you have signed consent to communicate via electronic mail)

Individuals with financial involvement:

We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care. We will only release this information if you previously gave written consent.

As required by federal, state and local law

We may use and disclose your health information without your consent for the following purposes:

Administrative and Judicial Proceedings:

If you are involved in a legal proceeding we may disclose your health information in response to a court order, response to a subpoena, or other lawful process.

Law Enforcement:

We may disclose your health information to law enforcements officials for the following but not limited to:

- To identify or locate a suspect, fugitive, material witness, or missing person
- To report a crime
- To report criminal conduct we believe in good faith to have occurred on our premises
- To report if we believe a patient has been the victim of abuse, neglect or domestic violence

Public Health Services:

We may use and disclose your health information for public health services for the following but not limited to:

- To prevent or control disease, injury, or disability
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition
- To report birth or death
- To report abuse or neglect to a child or adult
- To report adverse events, product defects or problems
- To track FDA regulated products
- To notify people to enable product recalls

Organ/Tissue Donor:

We may disclose use or disclose your health information if you are a registered as an organ donor to organizations that handle an organ donation bank.

Medical examiners, Coroners, and Funeral Directors:

We may use and disclose your health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also disclose your health information to funeral directors to assist them in performing their job duties.

Workers Compensation:

We may disclose your health information for workers' compensations for clarification of claims to workers' compensation.

Military and Veterans Activities:

We may disclose your health information to military command authorities if you are or where a member of the Armed Forces.

National Security:

We may disclose your health information to authorized federal officials for any national security activities authorized by law.

Inmates:

We may disclose your health information, if you are an inmate of a correctional institution or under the custody of the law, to assist in providing you health care, protecting your health and safety for yourself and or others.

Research:

We may disclose your health information for research purposes if you are enrolled in a research program. All research programs are subject to guidelines and processes to protect your information in you are enrolled in a research protocol. We may also disclose your health information to people who are preparing to conduct a research project. We may give them information to help them look for patients with specific medical needs that met the protocol of a particular research project.

There may be other uses and disclosures of your medical information not mentioned by this notice. We will only disclose your health information if you authorize us to disclose the information. If you authorize us to use or disclose your information, you may, at anytime revoke that authorization in writing. If you revoke your authorization, we will no longer use or disclose your health information as you specify, except to the extent that we have to comply with federal, state and local laws.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information that we maintain about you:

Right to Request Copies and or Review:

You have the right to review and receive a copy your health information about your care. This includes your medical information as well as billing information. This does not include information that is collected in anticipation of, or use in, a civil, criminal or court proceeding. To review or receive a copy of your health information you must submit your request to management of MBCCC. **Please note:** If you request copies of your health information, we may charge a fee for the cost of copying, preparing and mailing the requested documents. We may deny your request to review and copy your records in certain circumstances. If you are denied access to your health information you may request that the denial be reviewed by a licensed health care professional chosen by MBCCC. We will comply with the outcome of the review.

Right to Amend:

You have the right to request we amend your information if you feel that your health information in incorrect or incomplete. To request an amendment you must submit your request to the management of MBCCC, these forms are available at the reception desk. We may deny your amendment request, if this occurs, you will be notified of the denial reason and given the opportunity to file a written statement of disagreement with MBCCC.

Right to Request Restrictions:

You have the right to specify or restrict how we use and disclose your health information for treatment, billing, payment or other health care operations. Please note: We are not required to agree with your request, if the information needed is for emergency treatment or required by law. To request restrictions you must submit in writing to the management of MBCCC.

Right to Request Confidential Communications:

You have the right to request that we communicate with you in a certain manner. For example you may request we only communicate/contact you at work or by email. To request confidential communications you must make your request in writing to the management of MBCCC.

Right to an Accounting of Disclosures:

You have the right to request an accounting of certain disclosures we make of your health information. Certain disclosures need not be included such as those made for treatment, payment or health care operations. To request and accounting of disclosures you must request in writing to the management of MBCCC. Your request must state the time period you would like to be disclosed.

Right to a copy of this Notice:

You have the right to receive a copy of this notice at any time, even if you previously received this notice.

Changes to this Notice

We reserve the right to changes the terms of this notice at any time. We reserve the right to make the new notice provisions effective for all health information we currently have or will obtain in the future. If any changes are made to our privacy practice we will promptly notify you.

MOUNTAIN BLUE
CANCER CARE CENTER

Acknowledgement of NPP & Authorization to Release PHI

This Organization has published a HIPAA 'Notice of Privacy Practices' (NPP). I have been informed and provided a copy of the NPP. Please check one item below:

_____ NPP Provided _____ NPP Previously Provided _____ NPP Declined

The Patient agrees that this Organization may disclose the following types of information if contained in the Patient's medical - billing records (please initial the appropriate categories):

_____ HIV / AIDS Information _____ Mental Health Information _____ Substance Abuse Information
_____ Sexually Transmitted Disease Information _____ Pregnancy Information (if Patient under Age 18)
_____ Medical Information

This Organization will utilize the patients address and telephone numbers for communications unless an alternate form of communications (please initial and complete appropriate items below):

_____ E-mail
Fill in appropriate e-mail address: _____
_____ Regular mail with security envelopes

_____ Via other telephone number _____

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENTVERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____
Print Name

_____ _____ _____**AM / PM**
Patient or Legally Authorized Representative **Date Time**

_____
Relationship to Patient If Signed By Another Party

799 E. Hampden Ave., Suite 500 • Englewood, CO 80113
Phone: 303.953.7400 • Fax: 303.953.7401