200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: **269-373-7478**

WMCC

**West Michigan Cancer Center**

**Radiation & Surgical Specialties**

WMCC #

# ADMINISTRATIVE

## *WELCOME TO*
## *WEST MICHIGAN CANCER CENTER RADIATION & SURGICAL SPECIALTIES*

**In order to make your visit as easy as possible, please review the information below:**

- **What to bring:**
  - Your completed *Health History* (the questionnaire attached to this form)
  - All health and prescription insurance cards
  - Photo ID
  - Medication list and/or bottles (pharmaceutical, vitamins, and supplements)
    - In the medication list, include:
      - Date prescribed
      - Amount taken daily
      - What it is for
      - Who prescribed it to you
      - Medications you don't take daily
  - Legal Paperwork if applicable (Durable Power of Attorney for Health Care, Do Not Resuscitate (DNR), Guardianship paperwork)

**Where to go:**
Map of location - a map is enclosed
Free WMCC parking is located:
In front of the building / Overflow lot is on the north side of the building (Eleanor & Park Street)

***NOTE***: Park in front of the signs that say: *WMCC patient reserved parking.*

  - Check in on the first floor at the registration desk.
    - We will request your Insurance Cards and Photo ID.
    - We will verify your address, contact numbers, emergency contact, etc.

- **Arrival time:**
  - Your appointment is on: at:
    with Dr.
  - If this date or time does not work with your schedule, then please contact us.
  - We anticipate your appointment will last:

**For the safety of other patients/caregivers at the Center, please:**

- Avoid using scented products on the day of your appointment (hairspray, cologne/perfume, body wash/lotions, etc).
- Do not bring nut products (mixed nuts, peanut butter snacks, etc).

More questions? Please call us at (269) 382-2500 or visit our website at www.wmcc.org

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# ADMINISTRATIVE

For your first visit with us, please bring the following:

- All current health insurance cards
- All current health prescription cards

Most insurance companies require the patient to share in the cost of medical care. When a physician prescribes any type of treatment or medication, the patient or patient's legal guardian should expect to pay a part of the cost. Forms of patient responsibility are usually divided into three groups:

**Deductible -** The fixed annual amount that your health plan expects you to pay before your coverage kicks in. Typical deductible amounts are $250, $500, or $1,000, per person or family.

**Co-insurance -** The percentage that your insurance does not cover. Traditional plans pay 70% to 90%. Co-insurance is the percentage remaining after your health plan has made their payment.

**Co-payment -** An on-going responsibility for the patient to pay. Your plan may require you to pay $10, $15, or $20 for each time you see the physician or are treated by our office.

**Pre-Authorization –** We make every effort to obtain pre-authorization for treatments and medication which are prescribed by our doctors.

**Billing**
We file a claim with your insurance carrier first. After your insurance carrier has processed the claim, we will mail you a statement showing any remaining balance due. Statements are mailed within the first 5 business days of each month. If you have questions about your statement, or other billing concerns, please call our on-site billing representatives for assistance at 269-373-7429. You may also call our billing department directly (Radiation Business Solutions) at 866-353-0360.

If you have concerns about making payments on your bill, or have other coverage related concerns, please contact a Patient Financial Counselor at 269-384-8679 or 800-999-9748 (within Michigan), or by e-mail at: pfc@wmcc.org. Our on-site financial counselors are ready to answer any questions you may have concerning payment or insurance.

**Patient Financial Counseling**
Insurance can be complex and intimidating. Our financial counselors can assist with understanding insurance, applying for financial assistance, open enrollment process and more. Cancer is expensive and our trained staff are here to help you and your loved one with providing guidance and assistance mitigating the financial burdens of cancer care.

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# ADMINISTRATIVE

## PATIENT CARE SERVICES

West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) is committed to providing comprehensive, patient care services free of charge to help you and your caregivers. To access them, please ask the care team for more information; or call the main number for assistance: (269) 382-2500.

**Cancer Information Resources**:
Free educational cancer resources are available in the lobby areas which include community resources. Some exam rooms also have touch screens with educational information that you may find helpful. If you would like any assistance, please contact your care team.

**Massage Therapy:**
Massage therapy services are available to WMCC patients and caregivers, Monday through Friday from 9:00 pm to 3:00 pm. Licensed massage therapists provide back, hand and shoulder massage in 10 minute time slots while you are on site for a scheduled visit. You must register for this service by calling our social services department at 269-384-8629 or email socialwork@wmcc.org.

**Medical Social Work**:
Clinical social workers experienced in oncology can help with a wide array of issues from brief counseling for emotional support to local and national resources.

**Nutritional Services**:
Clinical registered dietitians experienced in oncology can help with nutrition questions, changes in food consumption, and empowering patients to pursue optimal nutrition.

**Lodging and Transportation**:
Due to COVID-19, there could be modifications to this resource. Ask your care team about possible lodging and transportation options for your and your loved one.

**Wellness Programming**:
Due to COVID-19, wellness programming has been put on hold. Please check out website for any updates to these programs.

**Survivorcise and LIVESTRONG Program**:
Due to COVID-19, these exercise programs have been put on hold. Please check our website for any updates for these programs.

**Volunteer Services**:
Due to COVID-19, our compassionate and dedicated volunteers are remaining at home for the their safety as well as that of our patients and staff. Please check our website for future updates.

**Patient Experience**:
WMCC is committed to quality and safe care. Throughout your journey with us, we would appreciate your feedback for improving care. Our organization engages in a variety of quality measures and programming. You or your loved one may be asked to complete a survey, participate in a focus group, or provide direct verbal feedback about your experiences. We welcome constructive feedback, and are committed to quality improvement. Please share concerns with your care team.

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# PATIENT DEMOGRAPHICS

**NAME (Last, First, Middle Initial):** _____

**DOB:** _____ **AGE:** _____ **SS#:** _____

**ADDRESS:** _____

**CITY:** _____ **STATE** _____ **ZIP CODE:** _____

**EMERGENCY CONTACT NAME / RELATIONSHIP:** _____

**EMERGENCY CONTACT PHONE:** _____ Hospital Preference: ☐ Borgess ☐ Bronson

**GENDER** ☐ Female ☐ Male ☐ Genderqueer ☐ Transgender Female ☐ Transgender Male ☐ Other

**SEXUAL ORIENTATION** ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Homosexual ☐ Straight ☐ Other

**RACE** ☐ Black / African American ☐ American Indian / Alaskan ☐ White / Caucasian ☐ Asian

☐ Pacific Islander / Hawaiian Native ☐ Unknown ☐ Decline to Provide ☐ Other

**ETHNICITY** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Provide

**MARITAL STATUS** ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

**COMMUNICATION** Work Phone: _____ Cell Phone: _____

Home Phone: _____ Preferred Contact Method: ☐ Home ☐ Work ☐ Cell

E-Mail Address: _____

**EDUCATIONAL LEVEL** Highest Level of Education Received?: _____

Can you read?: ☐ YES ☐ NO Can you write?: ☐ YES ☐ NO Primary Language: _____

Will you need a free translator?: ☐ YES ☐ NO Will you bring your own translator?: ☐ YES ☐ NO

**PRIMARY INSURANCE COVERAGE** Name of Coverage: _____

Member ID: _____ Group ID: _____

**SECONDARY COVERAGE** Name of Coverage: _____

Member ID: _____ Group ID: _____

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Patient Name: _____

# HEALTH HISTORY QUESTIONAIRE – SURG ONC

Today's Date: ___/___/____ Attending Physician (Office Use): _____

Patient Name: _____ DOB: ____/___/___ Age: _____

Individual completing this form (Relationship to patient): _____

## PAST MEDICAL HISOTRY

Please indicate if your doctor has diagnosed you with any of the following

| | | |
|---|---|---|
| ☐ Stroke | ☐ Asthma | ☐ Bladder Leakage |
| ☐ Seizure Disorder | ☐ Chronic Bronchitis | ☐ Bladder Prolapse |
| ☐ Neuropathy | ☐ Emphysema | ☐ Enlarged Prostate |
| ☐ Cataracts | ☐ Tuberculosis | ☐ Osteoarthritis |
| ☐ Glaucoma | ☐ Diabetes | ☐ Gout |
| ☐ Difficulty Hearing | ☐ Crohn's Disease | ☐ Osteoporosis |
| ☐ Thyroid Goiter | ☐ Ulcerative Colitis | ☐ Collagen Vascular Disease |
| ☐ Hyperthyroidism | ☐ Hernia | ☐ Lupus |
| ☐ Hypothyroidism | ☐ Intestinal Bleeding | ☐ Scleroderma |
| ☐ High Blood Pressure | ☐ Ulcer | ☐ Anemia |
| ☐ Heart Murmur | ☐ Gallstones | ☐ Other Blood Disorders |
| ☐ Rheumatic Fever | ☐ Jaundice/Hepatitis | ☐ Blood Clot Legs/Lung (DVT/PE) |
| ☐ Angina | ☐ Cirrhosis of Liver | ☐ HIV/AIDS Positive |
| ☐ Heart Attack | ☐ Pancreatitis | ☐ Metal Fragments in Body |
| ☐ Heart Failure | ☐ Spastic / Irritable Colon | |
| ☐ Irregular Rhythm | ☐ Kidney Stones | |

Other Health Conditions:

_____

## CANCER/TREATMENT FOR CANCER

| | | |
|---|---|---|
| Previous Cancer Diagnosis? | ☐ YES ☐ NO | Type: |
| Previous Radiation Treatment? | ☐ YES ☐ NO | Year & Treatment Area: |
| Radiation for Non-cancer? | ☐ YES ☐ NO | Year & Treatment Area: |
| Previous Chemotherapy? | ☐ YES ☐ NO | Year & Type: |

## SCREENINGS

| PROCEDURE | YEAR | ABNROMAL |
|---|---|---|
| ☐ Colonoscopy | | ☐ YES ☐ NO |
| ☐ Mammogram | | ☐ YES ☐ NO |
| ☐ Pap Smear | | ☐ YES ☐ NO |

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Patient Name: _____

# HEALTH HISTORY QUESTIONAIRE – SURG ONC

## SURGICAL HISTORY: Please select all that apply

| | |
|---|---|
| ☐ Coronary Artery Bypass Graft (CABG)<br>☐ Cataracts ☐ Left ☐ Right<br>☐ Cholecystectomy (Gall Bladder)<br>☐ Appendectomy<br>☐ Heart Stent / Replacement<br>☐ Heart Valve / Replacement<br>☐ Hip Replacement ☐ Left ☐ Right<br>☐ Knee Replacement ☐ Left ☐ Right<br>☐ Tonsillectomy | ☐ Breast Biopsy ☐ Left ☐ Right<br>☐ Breast Lumpectomy ☐ Left ☐ Right<br>☐ Breast Mastectomy ☐ Left ☐ Right<br>☐ Tubal Ligation<br>☐ Hysterectomy<br>☐ Ovary Removal ☐ Left ☐ Right<br>☐ Other Surgery:<br>_____ |

## SOCIAL HISTORY

Are you currently employed? ☐ YES ☐ NO ☐ RETIRED Occupation: _____

Are you Disabled? ☐ YES ☐ NO If yes, Disability? _____

Who do you live with: _____

Do you have any transportation concerns: _____

Do you drink alcohol? ☐ YES ☐ NO Type: _____ Daily Intake: _____

Do you use Marijuana? ☐ YES ☐ NO Last used: _____ How often: _____

Current or past tobacco smoking: ☐ YES ☐ NO Last used: _____

Peak packs per day: _____ For how many years: _____

Current or past chewing tobacco? ☐ YES ☐ NO Last used: _____

Current or Past Recreational Drug Use: ☐ YES ☐ NO Type: _____ Last Used: _____

## FAMILY HISTORY

Please indicate if anyone had more than one type of cancer. Attach additional sheet if needed.

| RELATIONSHIP | TYPE OF CANCER | AGE OF DIAGNOSIS | SIDE OF FAMILY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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Patient Name: _____

# HEALTH HISTORY QUESTIONAIRE – SURG ONC

## ALLERGIES

Allergies: _____

_____

## CURRENT MEDICATIONS

Name of Pharmacy: _____

Please list all medications, including over-the-counter and herbal supplements. Please note if at any time your WMCC provider prescribes a controlled substance, you will be asked to sign a Controlled Substance Agreement per policy.

| MEDICATION | DOSAGE | PRESCRIBING PROVIDER |
|---|---|---|
| | | |
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## REVIEW OF SYSTEMS

Please indicate if you experienced any of these symptoms in the last six months

**Eyes**
☐ Blurred Vision
☐ Double Vision
☐ Pain

**ENT**
☐ Ear Infection
☐ Sore Throat
☐ Sinus Problems
☐Loss of Smell
☐ Ringing in Ears

**Cardiovascular**
☐ Chest Pain
☐ Varicose Veins

**Gastrointestinal**
☐Abdominal Pain
☐Nausea
☐ Vomiting
☐ Indigestion
☐ Heart Burn
☐ Diarrhea
☐ Constipation
☐ Dark Stools
☐ Rectal Bleeding

**Genitourinary**
☐ Vaginal bleeding
☐ Not able to urinate
☐ Pain during urination
☐ Urinating frequently
☐ Urinate at Night
# of times _____

**Skin**
☐ Skin Rash
☐ Boils
☐ Persistent itch

**Musculoskeletal**
☐ Change in height
☐ Joint pain
☐ Neck pain
☐ Back pain

**Neurological**
☐ Tremors
☐ Dizzy spells
☐ Numbness/Tingling
Location: _____
☐ Memory Changes

**Constitutional Systems**
☐ Fever
☐ Chills
☐ Headache
☐ Night sweats
☐ Hot flashes
☐ Loss of appetite
☐ Loss of taste
☐ Change in weight
☐ Loss ☐ Gain
# of lbs _____

Daily water intake: _____

Other _____

**Endocrine**
☐ Excessive thirst
☐ Too hot/ ☐ Too cold
☐ Fatigue

**Hematologic/ Lymphatic**
☐ Swollen glands
☐ Blood clotting problems

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# HEALTH HISTORY QUESTIONAIRE – SURG ONC

## PSYCHOLOGIC

Are you happy with your life? ☐ YES ☐ NO Are you severely depressed? ☐ YES ☐ NO

Have you considered harming yourself? ☐ YES ☐ NO

Have you or have you ever been on anti-depressant or anti-anxiety medication? ☐ YES ☐ NO

Have you been hospitalized for any psychiatric/ mental health reason? ☐ YES ☐ NO

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# NEEDS INTAKE ASSESSMENT: PSYCHOSOCIAL STRESS SCREENING

In compliance with The American College of Surgeon's Commission on Cancer, the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) provides you with free services regarding coping with illness and the changes it can bring to you and your family. This form will be reviewed by your physician and a social worker to coordinate appropriate services for quality care. ***Please print clearly to ensure timely response to your needs.***

Today's Date:_____ Name:_____ Date of birth:_____

Address:_____

Phone:_____ Who is filling out this form (and relationship):_____

WMCC Physician:_____ Were you in the military and honorably discharged? ❑ Yes ❑ No When?_____

Do you have a medical advocate? This is someone you requested to make medical decisions if/when you cannot communicate your wishes; and is called a Durable Power of Attorney for Medical Care. ❑ Yes ❑ No if no, would you like information? ❑ Yes ❑ No

Has a judge ordered another adult to help you make legal decisions? (legal guardian)? ❑ Yes ❑ No If yes, name:_____

What is your understanding of your appointment at WMCC today? _____

_____

What is your highest level of completed education: _____ Primary language: _____

❖ ***Stress Scale***: Many people find doctor's appointments stressful. On a scale of one to ten, with ten being the worst amount of stress, and zero being the least amount of stress, please circle your level of stress today.

0 1 2 3 4 5 6 7 8 9 10

**Low stress** **Medium stress** **High stress**

Are you a parent concerned about discussing your diagnosis with your under-aged children? ❑ Yes ❑ No

## Check all of the areas below that contribute to your stress and that you are currently experiencing:

| Currently having issues with meeting basic needs | Currently experiencing | Do you have a history of mental health issues |
|---|---|---|
| ❑ Housing Crisis<br>❑ Financial Distress<br>❑ Insurance<br>❑ Transportation Limitations<br>❑ Employment<br>❑ Family Relationships<br>❑ Abuse or Neglect<br>Do you feel safe at home?<br>❑ Yes ❑ No<br><br>(**Please note**: If you indicate you ***do not feel safe at home***, clinicians reviewing this form are mandated reporters and required by law to call you to discuss safety.) | ❑ Fear<br>❑ Anxiety<br>❑ Sadness<br>❑ Worry<br>❑ Anger<br>❑ Spiritual concerns<br>❑ Increase in substance use<br>❑ Other:<br>_____<br><br>Are you currently being treated for a mental health condition?<br><br>_____<br><br>By whom?_____ | ❑ Clinical Depression<br>❑ Clinical Anxiety<br>❑ Substance use/addiction<br>❑ Past psychiatric hospitalization<br>❑ Family history of mental health issues<br>❑ Past thoughts or attempts of self harm<br>❑ Currently seeing a counselor/psychiatrist<br>❑ Currently on mental health medication?<br><br>❑ Other: _____ |

As part of your care team, WMCC has clinical social workers specialized in blood disorders and cancer care. Would you like a clinical social worker to contact you for follow up for resources and support for issues noted above: ❑ Yes ❑ No

➢ ***WMCC Staff Processing: Original document to the assigned social worker, copy to physician.*** ➢

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Patient Name:
_____

# NUTRITION SCREENING

In compliance with The American College of Surgeon's Commission on Cancer, the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) provides you with free services regarding information on nutrition and diet changes through treatment. This form will be reviewed by your physician and a registered dietitian to coordinate appropriate services for quality care.
***Please print clearly to ensure timely response to your needs.***

Height: _____ Weight: _____

Have you had recent "***unintentional***" weight loss in the past month? ❑ Yes ❑ No

If yes, how much? _____

Have you had any recent "***unintentional***" weight loss in the past six months? ❑ Yes ❑ No

Have you experienced any of the following problems in the past month?

1. Nausea and/or vomiting lasting more than three days? ❑ Yes ❑ No
2. Diarrhea (more than three **liquid** stools per day)? ❑ Yes ❑ No
3. Loss of appetite lasting more than three days? ❑ Yes ❑ No
4. Difficulty or pain with chewing or swallowing? ❑ Yes ❑ No

Do you currently have a feeding tube? ❑ Yes ❑ No

If yes, for how long? _____

Who do you receive your supplies from? _____

Are you currently receiving TPN (nutrition through your vein)? ❑ Yes ❑ No

If yes, for how long? _____

Who do you receive your supplies from? _____

Would you like to be contacted by a Registered Dietitian (RD)? ❑ Yes ❑ No

If yes, what would you like to discuss? _____

➢ ***WMCC Staff Processing: Original document to dietitian team, copy to physician.***

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Patient Name: _____

# AUTHORIZATION FOR THE RELEASE OF HEALTH CARE INFORMATION

I authorize, the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC), to release verbally or in print of the following healthcare information regarding:

_____/_____/_____

(Patient's Name – Please Print) (Patient's Date of Birth)

**Records relating to visit(s) / service(s) of**: _____

**(Specific dates or services, or can list "ALL")**

**Purpose of Disclosure:** (i.e., individual's request, insurance, continuing care)

_____

**This authorization will expire**: ☐ Indefinitely ☐ Specific Date: _____

**Information to be released:**

- ☐ Consultation(s) & follow-ups
- ☐ Appointment Time/Location
- ☐ WMCC Images on a Disc
- ☐ Laboratory Report(s) & Pathology
- ☐ Printed Radiology Reports (CT/MRI)
- ☐ Other:
- ☐ Insurance & disability forms
- ☐ Billing & payment information
- ☐ Support Services (Nursing, Nutrition)
- ☐ Health History Questionnaire
- ☐ Prescriptions & Medications
- ☐ Correspondence
- ☐ Genetic records
- ☐ Operative Report
- ☐ Consents
- ☐ Education

_____

In order to protect our patients, **specific authorization is required** to release certain information. If any of the following apply, and you wish to have that information released, you must place your initials on the line next to the appropriate line:

___ Treatment of emotional illness, including documentation by any psychologist or psychiatrist (**does not** include psychotherapy notes)
___ Treatment of alcohol or substance abuse
___ Documentation by Social Service personnel
___ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex
___ Treatment of venereal disease, tuberculosis or communicable disease as specified by the Michigan Department of Public Health

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Patient Name: _____

# AUTHORIZATION FOR THE RELEASE OF HEALTH CARE INFORMATION

**Information is to be released to:**

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

This authorization may be revoked at any time by notifying the organization in writing at West Michigan Cancer Center Radiation & Surgical Specialties (WMCC), Privacy Officer, 200 N. Park St., Kalamazoo, MI 49007, but this will not affect disclosures made prior to receipt of the revocation.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization. Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to redisclosure by the recipient and will no longer be protected by the HIPAA Privacy Rule.

By signing this Authorization, I acknowledge that I have read it and that I understand it.

SIGNED_____ DATE___/____/_____
(Patient or Authorized Representative)

PRINTED Patient or Authorized Representative Name: _____

Description of Authorized Representative's Authority to Sign _____