HELLO!

Welcome to Nebraska Cancer Specialists!

This is a brief overview of what to expect during your office visit, as well as some of the services we provide. If you wish, it may be helpful to bring someone with you to listen and take notes during your visit. While you are cared for by many physicians, our care for you can often times be complex. **Please Call us Early and Call Us First** if you are being sent to the ER by another physician.

Arrival

Upon arrival, our Patient Schedulers will greet you and ask for your driver's license or current photo ID, your insurance card(s), and have you complete any necessary forms. They will scan your cards and completed patient forms into your electronic chart. They will also ask to take your picture for your chart so our medical staff can easily identify you. You will then complete the check in process.

A Medical Assistant will then greet you to obtain your vital signs and review your current medications with you. Due to potential drug interactions, it is important for you to know all of your current medications or bring the bottles with you. Please include vitamins, herbals, and over-the-counter medications. Your physician will review and complete your health history, followed by a physical exam if indicated. He/she will discuss your diagnosis and management plan. If you have any questions about your diagnosis and/or treatment, please let your physician know; we encourage you to ask questions. If your physician recommends treatment, it will be done in the treatment area of the clinic. In most cases treatment will not be started on your first visit, unless your physician has already discussed this with you.

Please Call us Early and Call Us First if you are being sent to the ER by another physician.

Appointment Time

Our goal is to see our patients as close to their appointment time as possible. We strive to keep waiting times to a minimum, please realize delays can occur due to emergencies and unforeseen patient needs. If you arrive more than 30 minutes prior to your scheduled appointment time, you will be seen closer to your appointment time. If you arrive more than 30 minutes late for your appointment, you will be asked to reschedule.

Patient Portal

Our practice utilizes Navigating Care. The patient portal allows convenient and secure online access to your Personal Health Record. Access gives you up-to-date information about your diagnosis, medications, and lab results.

NEBRASKA CANCER SPECIALISTS

17201 Wright Street
Suite 200
Omaha, NE 68130
Phone (402) 334-4773
Fax (402) 330-7463

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Advanced Practice Providers:

At times you will be seen by an Advanced Practice Provider (Nurse Practitioner or Physicians Assistant). These clinicians have an advanced degree, allowing them to make medical decisions and order treatments/medications. They work in close collaboration with your physician.

Check-out

Following your appointment, you will check-out with our patient schedulers, who will schedule your next appointment as well as any necessary tests or procedures recommended by your physician. **Please note: Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.**

Appointment Reminders

Our practice uses an appointment and balance reminder system. You may receive an email, phone call, or text message with this information. At any point, you may opt out of these reminders.

Nurse Case Managers

Remember to Call Us Early, Call Us First! Your nurse case manager is the contact person for any questions or concerns that may arise between office visits. Our case managers are highly-trained oncology nurses with many years of oncology experience. Please leave a voicemail; calls for test results and non-urgent matters will be returned after urgent patient needs are met. For life-threatening emergencies, call 9-1-1. If you are in need of a prescription refill, contact your pharmacy directly. They will contact us for any authorization needed.

Patient Financial Services

Our patient financial services team is here to help you! We participate with most major insurance plans including Medicare and Medicaid, and we will verify your insurance prior to your office visit. You may find it helpful to check with your insurance ahead of time to determine if our physicians are considered “in-network” for your plan. Once you and your physician have determined a treatment plan (if needed), patient financial services will verify benefits with your insurance company.

Your co-payment must be paid at the time of your office visit. Payment options include cash, check, Visa, MasterCard, American Express, and Discover. We will submit charges to your insurance company and send you a bill for any deductible and/or uncovered portion of the charges. Please note that any services such as tests and procedures that are provided outside of our office will be billed to you directly by

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the provider of those services. The bill you receive from Nebraska Cancer Specialists is separate from other bills you may receive from the hospital or other physicians.

Our patient financial services team is available to answer any questions you might have about reimbursement and payment. If you need assistance with your insurance requirements, we are here to help you. **Please feel free to contact patient financial services at 402.537.5600.**

By providing us with your phone number(s) or email address, you give your consent for us, our agents, and our collection agents to contact you at these numbers and to leave live or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an auto dialer.

Outpatient Pharmacy

As an added convenience for our patients, we dispense medications associated with your care from our outpatient pharmacy. We offer this service to ensure continuity of care. Ask a member of your medical oncology care team for more information.

Support Services

We offer many on-site and referral services that compliment your care. These include dietary, social work, clinical trials, genetic counseling, mental health counseling, survivorship, support groups, occupational therapy, image recovery, lymphedema specialists, and chaplain support. You may find websites like caringbridge.org or livestrong.org helpful as well.

Oncology Care Model

NCS has been selected to participate in the Medicare initiative called the Oncology Care Model (OCM). By doing so, we have agreed to a different way of being paid by Medicare. The goal is to provide our patients with even more coordinated high quality cancer care and to lower the overall cost of care.

PLEASE NOTE

In keeping with our intent to provide a safe and healthy environment, smoking is not allowed on any of our campuses; this includes e-cigarettes, vaping and smokeless tobacco. For the consideration of our patients and their families, we do not permit children in the treatment area or pets in the clinics. Due to potential patient allergies, latex balloons are not allowed. Privacy laws prohibit the use of cameras or video during your visit. We comply with applicable federal civil rights laws and don't discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services (free of charge) are available to you. Please request this service when scheduling your appointment.

We offer many onsite and referral services that compliment your care.

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Patient History and Review of Systems

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Name: _____

Date of Birth: _____

Today's Date: _____

Reason for Today's Visit: _____

_____

_____

PREVIOUS CANCER DIAGNOSES

Types of Cancer: _____

_____

Treatment Received and Where: _____

_____

PERSONAL MEDICAL HISTORY

Allergies/Type of reaction (ex. rash, itching):

_____

_____

_____

Illnesses/Medical History: _____

_____

_____

Past Surgeries: _____

_____

_____

_____

Do you have a Power of Attorney? ☐ YES ☐ NO
Do you have a Living Will? ☐ YES ☐ NO
Do you have a DNR order? ☐ YES ☐ NO

SOCIAL HISTORY

Currently Live With: _____

Alcohol (quantity per week): _____

Tobacco Use (circle): ☐ CURRENT ☐ NEVER ☐ PAST ☐ CIGARETTES ☐ CIGARS ☐ E-CIGARETTES ☐ CHEWING

Amount smoked per day: _____

Year started _____ **Year quit** _____

Illegal Drug Use (circle): ☐ YES ☐ NO

Marijuana Use (circle): ☐ YES ☐ NO

WORK HISTORY

Occupation(s): _____

_____

Military Service (past or present): _____

_____

Any exposure to toxins, fumes, radiation, or chemicals? (circle): ☐ YES ☐ NO
If yes, what types?_____

_____

FAMILY MEDICAL HISTORY

Please include parents, grandparents, siblings, aunts, and uncles.

Relative	Illness	Age at Diagnosis	Alive/Deceased

Patient Learning Needs Assessment

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I learn best by: (Please check all that apply)

- ☐ Doing
- ☐ Hearing
- ☐ Reading
- ☐ Writing

I have the following condition(s) that may affect my learning:

- ☐ Vision concerns
- ☐ Hearing concerns
- ☐ Reading difficulty
- ☐ Other _____
- ☐ None (can select all that apply)

Please list any other questions, concerns, or special needs that your provider needs to know about (optional)

_____

_____

_____

NAME: _____ **DATE OF BIRTH:** _____

REVIEW OF SYSTEMS

CONSTITUTIONAL YES NO
Weight loss in past year ☐ ☐
Fever in last month ☐ ☐
Night sweats ☐ ☐
Fatigue ☐ ☐
Appetite change ☐ ☐

EYES, EARS, NOSE, THROAT YES NO
Blurred or double vision ☐ ☐
Nose bleeds ☐ ☐
Hearing loss ☐ ☐
Mouth sores ☐ ☐
Sore throats ☐ ☐
Hoarseness ☐ ☐
Trouble swallowing ☐ ☐
Sinus problems ☐ ☐

RESPIRATORY YES NO
Shortness of breath ☐ ☐
Cough ☐ ☐
Coughing up blood ☐ ☐
Bronchitis ☐ ☐
Pneumonia ☐ ☐
Emphysema or COPD ☐ ☐
Asthma ☐ ☐
Blood clots to lung ☐ ☐
Flu Shot ☐ ☐
Date last received: _____
Pneumonia Shot ☐ ☐
Date received: _____

CARDIOVASCULAR YES NO
Chest pain ☐ ☐
Palpitations ☐ ☐
Swelling in feet or legs ☐ ☐
High blood pressure ☐ ☐
Heart valve disease ☐ ☐
Heart murmurs ☐ ☐
Coronary artery disease ☐ ☐
High cholesterol ☐ ☐
Previous heart attack ☐ ☐
Congestive heart failure ☐ ☐
Irregular heart beat ☐ ☐
Blood clots to leg/arm ☐ ☐

SKIN YES NO
Rash ☐ ☐
Itchiness ☐ ☐

GASTROINTESTINAL YES NO
Nausea/ vomiting ☐ ☐
Abdominal pain ☐ ☐
Liver disease/hepatitis ☐ ☐
Peptic ulcers ☐ ☐
Diarrhea ☐ ☐
Rectal bleeding ☐ ☐
Constipation ☐ ☐
Colonoscopy ☐ ☐
Date last performed: _____
Sigmoidoscopy ☐ ☐
Date last performed: _____
Other Scope ☐ ☐
Date last performed: _____
Cologuard ☐ ☐

HEMATOLOGIC YES NO
Anemia ☐ ☐
Low platelet counts ☐ ☐
Enlarged lymph glands ☐ ☐
Abnormal bleeding ☐ ☐
Familial thalassemia ☐ ☐
Excessive bruising ☐ ☐

ENDOCRINE YES NO
Diabetes ☐ ☐
Thyroid disease ☐ ☐

NEUROLOGICAL YES NO
Headaches ☐ ☐
Dizziness ☐ ☐
Fainting ☐ ☐
Seizures ☐ ☐
Difficulty walking ☐ ☐
Numbness feet/hands ☐ ☐
Stroke ☐ ☐

PSYCHOSOCIAL YES NO
Depression ☐ ☐
Anxiety ☐ ☐
Insomnia ☐ ☐
Mental illness ☐ ☐
Drug abuse ☐ ☐
Alcohol abuse ☐ ☐

MUSCULOSKELETAL YES NO
Arthritis ☐ ☐
Osteoporosis ☐ ☐
Joint pain ☐ ☐
New bone pain ☐ ☐
Fractures (in past 2 yrs) ☐ ☐

GENITOURINARY YES NO
Pain with urination ☐ ☐
Blood seen in urine ☐ ☐
Bladder infections ☐ ☐
Kidney infections/stones ☐ ☐
Kidney disease ☐ ☐

****MALES ONLY**** YES NO
Incontinence ☐ ☐
Slow Stream ☐ ☐
Dribbling ☐ ☐
Erectile Dysfunction ☐ ☐
Prostate/Rectal Exam ☐ ☐
Date last performed: _____
PSA drawn ☐ ☐
1st result: _____
Most recent result: _____

****FEMALES ONLY****
GYNECOLOGICAL YES NO
Fibrocystic ovaries ☐ ☐
Fibrocystic breasts ☐ ☐
Date of last mammogram: _____
Any breast biopsies in past ☐ ☐
Date of last pap/pelvic exam: _____
Currently Pregnant ☐ ☐
Desire for fertility ☐ ☐
# of pregnancies__# of children __
spontaneous
abortion/miscarriage _____
# of therapeutic abortions _____
Breast Feed ☐ ☐
Age at first live birth: _____
Age menstrual periods began ____
Date of last menstrual period __
Menstrual cycle length ___ days
Menopause Status ☐Pre ☐Peri ☐Post
Age when menopause began __
Taking hormonal therapy ☐ ☐
How long _____ Type _____
Taking birth control past or present
_____
How long _____ Type _____
Number of Living Children _____

Anything else you would like your doctor to know, please describe below: _____

_____

_____

Medication List

NEBRASKA CANCER SPECIALISTS

Patient Name Date of Birth

Preferred Pharmacy

Pharmacy Address

Medications (include vitamins, herbals, and over-the-counter)	Prescriber (Dr.'s name who prescribes medication)	Dose	How often?

If you are unable to fill out the medication list, please bring a list of your medications with you to your first appointment.

Medical Insurance Information Form

Name _____ Date of Birth _____

Please present your insurance card and a driver's license or picture ID to the Patient Scheduler. Prior authorization may be required before you see one of our providers.

Assignment of Benefits

I hereby authorize Nebraska Cancer Specialists, the Physicians of Oncology Hematology West PC, to furnish my insurance company(s) or designated attorney, all information which they may require in order to issue payment. I herby assign all payment(s) for services rendered by NCS to be issued directly to Nebraska Cancer Specialists. This assignment applies to all dates of service until revoked.

I have requested medical services from Nebraska Cancer Specialists and understand by making this request I become fully responsible for any and all charges incurred in the course of the treatment.

_____ _____
Patient/Responsibility Party Signature Date

_____
Name of person who carries primary insurance Date of Birth Relationship to Patient

_____ _____
Witness Date

Medicare Recipients Only:

1. Is Medicare your primary insurance? ☐ Yes ☐ No
2. Are you receiving 'Black Lung' benefits? ☐ Yes ☐ No
3. Are services to be paid by a government research program? ☐ Yes ☐ No
4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at NCS? ☐ Yes ☐ No
5. Was this medical condition due to an accident? ☐ Yes ☐ No

   If yes, please explain if it was: work related, auto, injured at home, or other:
   _____
6. Are you or your spouse covered under an employer's health plan through your/their employment or that of a family member? ☐ Yes ☐ No

Consent to Treat, Notice of Privacy Practices
Patients' Rights & Responsibilities

NEBRASKA CANCER SPECIALISTS

I give permission for Nebraska Cancer Specialists (NCS) to render to me medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

My signature below acknowledges that I have been offered the Notice of Privacy Practices and Patient Rights and Responsibilities (a copy is available at the office upon request); and have agreed to the PCM program.

_____

Signature of patient or legal guardian Date

_____

Printed name of patient Printed name of legal guardian

_____

Witness Date

Request for No Information

Nebraska Cancer Specialists is committed to protecting our patient's privacy. Without authorization, messages left on answering machines, via voicemail, or with other individuals will be limited to the caller's name that they are calling from Nebraska Cancer Specialists, and the phone number to call. If you prefer that more complete information be provided, please fill out the form below.

Check which applies:

☐ OK to leave message

☐ Do not leave message

The following individuals CAN be given information:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

The following individuals CANNOT be given information:

Name: _____

Name: _____

_____ _____

Printed Name Date

_____ _____

Signature Relationship