

HELLO!

Welcome to Nebraska Cancer Specialists!

Hello!

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.

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.

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

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Patient History and Review of Systems



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

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

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? |
|--|--|------|------------|
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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 hereby 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



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.

NCS participates in the Medicare program called Principal Care Management or PCM. 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 care and coordination specific to your diagnosis and treatment plan. You may be responsible for coinsurance and have the right to withdrawal at any time.

At NCS we strive to keep patient medications up-to-date. This is important in order for providers to be aware of any interactions that may arise with treatment prescribed by NCS. I give permission for Nebraska Cancer Specialists (NCS) to access and download my prescription history from the Nebraska Drug Monitoring Program (PDMP) into the EMR.

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



Patient Learning Needs Assessment



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)

Patient Name: _____

Patient Date of Birth: _____

Today's Date: _____



Patient Health Questionnaire



Please circle the number (0 = none, 10 = worst) to describe any pain you may have today or have had since your last appointment.

0 1 2 3 4 5 6 7 8 9 10

1. **Where is your pain?** _____

2. **What are you doing to help your pain?** (circle below)

- Opioid (Hydrocodone/Oxycodone) -Heat/Cold -Non-Opioid(Tylenol/Advil)
 -Massage -Relaxation Techniques -See a Pain Specialist -Nothing

3. PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|------------|--------------|-------------------------|------------------|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

**** If you circled a 2 or a 3 above, please move on to next set of questions.**

| | | | | |
|---|---|---|---|---|
| Trouble falling asleep, staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself – or that you’re a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching TV | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

Column Totals: _____
 Add Totals Together: _____

4. ***If you checked off any problems,** how difficult have those problem made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all Somewhat difficult Very difficult Extremely difficult

Date of Appt. : / / **Name:** _____ **DOB:** / /