RCCA
REGIONAL CANCER CARE ASSOCIATES LLC®
CENTRAL JERSEY DIVISION
Expertise. Compassion. Dedication.

TAX ID NUMBER: 22-3141761
PATIENT INFORMATION

Today's Date: _____ Account #: _____

Staff Initials: _____

RCCA MD: _____

Patient Name: _____
Last First Middle

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Sex (please circle): Male / Female Marital Status (please circle): M S D W Other

Social Security #: _____ Date Of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact you at *all* of the above numbers? Yes No

E-Mail Address: _____ May we contact you through e-mail? Yes No

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____
Name *Relationship*

Primary Care Physician: _____ Phone: _____

Referring Physician (if different than PCP): _____ Phone: _____

SPOUSAL/PARTNER INFORMATION

Name: _____ Date Of Birth: _____ Social Sec. #: _____

Employer: _____ Address: _____

Phone Number: _____

PLEASE REVIEW AND COMPLETE THE FOLLOWING PAGES

REGIONAL CANCER CARE ASSOCIATES LLC
INSURANCE INFORMATION PAGE

Primary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

Secondary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

Tertiary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

With whom may we discuss financial matters? _____
Name

_____
Phone Relationship

INSURANCE RELEASE

I hereby authorize Regional Cancer Care Associates (RCCA) to release any information necessary to process my insurance claims acquired in the course of my examinations or treatment; and allow a photocopy of my signature to be used to process my insurance claims until I revoke this usage in writing. I authorize and direct my insurance carrier to issue payment checks directly to RCCA. In the event that my insurance carrier does not pay in full, I understand that I am ultimately financially responsible for any and all fees incurred and I agree to pay such fees in full. If I do not fulfill my contractual obligations with my insurance company, I understand that RCCA will forward my account to an outside collection agency for processing. The insurance information furnished here represents full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements, for any and all plans to which I subscribe, may cause me to incur full liability for professional charges as a result of non-payment by any of my insurance carriers.

Signature of Patient/Responsible Party: _____ Date: _____

Print Name: _____

REGIONAL CANCER CARE ASSOCIATES LLC
REQUIRED SIGNATURE FORMS

PERMISSION FOR RCCA TO RELEASE MEDICAL RECORDS TO OUTSIDE FACILITIES

I hereby request and authorize the employees of Regional Cancer Care Associates to disclose, make available, and furnish to physicians, hospitals, radiology groups, or any other persons involved in my medical care - all medical information related to my examinations, consultations, confinement and/or treatment, and to make copies or abstracts thereof, as required for my medical care.

Signature of Patient: _____ Print Name: _____

Date: _____

RADIOLOGY PRECERTIFICATION POLICY

Patients may schedule their own radiology exams (i.e. MRIs, PET scans, CT scans);
or they may request that our office schedule the exams.

Many insurance carriers *require precertification for radiology exams.* Precertification ensures that your insurance company will pay for the radiology exam that is ordered. In the event that your insurance company requires radiology exams to be precerted, our Radiology Precertification Clerks will contact your insurance company to obtain the precertification. It is *essential* that you notify our Precertification Clerks ***72 hours prior*** to the time of your exam in order to provide sufficient time for your insurance company to authorize the radiology exam. If you requested our office to schedule the radiology exam, we will automatically contact your insurance carrier for precertification; however, if you choose to personally schedule your exam, you are responsible for giving us the 72 hour notice, as stated above. In the event that you do not inform us of your exam; and precertification is not obtained in time, you will be responsible for any resulting costs from not receiving authorization prior to your exam.

I acknowledge that I have read and understand the RCCA Radiology Precertification Policy. I understand that I will need to give **72 hours notice** for all radiology exams that I schedule myself. In turn, I also understand that RCCA will be responsible for precertifying all radiology exams that I inform them of at least 72 hours ahead of time, as well as all exams that the office schedules for me.

Signature of Patient: _____ Print Name: _____

Date: _____

REGIONAL CANCER CARE ASSOCIATES LLC
PERMISSION FOR RCCA LLC TO REQUEST RECORDS FROM OUTSIDE FACILITIES

Patient Name: _____ Date of Birth: _____

RCCA Physician: _____

I hereby authorize the release of my medical records or copies of such to:

RCCA:

- ☐ J2 BRIER HILL COURT, EAST BRUNSWICK, NJ 08816
- ☐ 454 ELIZABETH AVENUE, SUITE 240, SOMERSET, NJ 08873
  For East Brunswick and Somerset Offices Phone: 732.390.7750 Fax: 732.390.7725

- ☐ 34-36 PROGRESS STREET, SUITE B-2, EDISON, NJ 08820
  For Edison office Phone: 908.757.9696 Fax: 908.757.9721

- ☐ STEEPLECHASE CANCER CENTER, 30 REHILL AVE., SUITE 2500, SOMERVILLE, NJ 08876
  For Somerville office Phone: 908.927.8700 Fax: 908.927.8706

Signature of Patient: _____

— — — — — — — —Office Use Only— — — — — — — —

To: _____ Date: _____

Please fax records on the above patient to:

East Brunswick and Somerset Fax: 732.390.7725
Edison Fax: 908.757.9721
Somerville Fax: 908.927.8706

☐ Consult/Office Notes ☐ Operative Reports ☐ Pathology Reports ☐ Laboratory Reports

☐ Radiology Reports (CT, MRI, X-Ray, Pet/CT, Mammogram, MUGA Scan)

☐ Radiation Treatment Records ☐ Chemotherapy Records ☐ Hospital Records ☐ Pathology Slides

Specific Requests: _____

_____

_____

Records must be received by: _____

Thank you for your assistance

REGIONAL CANCER CARE ASSOCIATES LLC
PHARMACY and PRESCRIPTION PLAN INFORMATION
REFERRAL INFORMATION

In order to efficiently and expediently process your prescription requests, we will need your pharmacy contact and prescription coverage information. RCCA also employs the use of an on-site pharmacy, and certain medications prescribed to you will be available directly through our office. Please provide us with the following:

Patient Name: ____

Pharmacy Name: ____

Pharmacy Phone Number: __________________________________

Pharmacy Fax Number: ____________________________________

Prescription Plan Name: ____________________________________Policy No: ____________________

_ _

Referral Information

Please tell us how you found out about Regional Cancer Care Associates. Circle your choice(s).

RCCA Patient

Family/Friend

Insurance Company

Referring Physician

Internet Search

Other:

____

____

REGIONAL CANCER CARE ASSOCIATES LLC
MEDICATION RECORD

Name: _____

Date: _____

PLEASE LIST ANY ALLERGIES: _____

_____

Medication	Frequency	Dosage	Ordering Physician	Date Began Medication

REGIONAL CANCER CARE ASSOCIATES LLC

PERMISSION TO RELEASE MEDICAL INFORMATION

I, _____ authorize
(Print Patient Name)

Regional Cancer Care Associates staff and physicians to release medical information (such as test results, plan of treatment, etc.) to the following people:

Name	**Relationship**
1) _____	
2) _____	
3) _____	
4) _____	
5) _____	

Please list the physicians you would like your consultation notes forwarded to:

Name	Address/Phone
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Date: _____

REGIONAL CANCER CARE ASSOCIATES LLC - CANCER FAMILY HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Health Care Provider: _____

Instructions: This is a screening tool for cancers that run in families, and this may or may not apply to you. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.
You and the following close blood relatives should be considered: *You, your Parents, Grandparents, and Great-Grandparents. Your Sons, Daughters, Grandchildren, and Great Grandchildren. Your Brothers, Sisters, Half-Siblings, Nephews, and Nieces. Your Aunts, Uncles and First-Cousins.* It is ok to give the approximate age of diagnosis if the exact age is not known.

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE of Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE of Diagnosis	RELATIVES on your FATHER'S SIDE	AGE of Diagnosis
X Y N	**EXAMPLE: BREAST CANCER**	**45**	**------**	**----**	**Aunt Cousin**	**45 61**	**Grandmother**	**53**
Y N	BREAST CANCER							
Y N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
Y N	UTERINE / ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS (Specify#)							
Y N	OTHER CANCER(S) (List cancer type*)							

*Among others, consider the following cancers: Melanoma, Pancreatic, Stomach, Gastric, Brain, Kidney Bladder, Small bowel, Sarcoma, Thyroid

Are you of Ashkenazi Jewish descent? Y N Are you concerned about your personal and/or family history of cancer? Y N

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Y N (Please explain/include copy of result if possible)

HEREDITARY CANCER RED FLAGS (To be completed with your healthcare provider- Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple negative breast cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome**(see cancer list below)

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology***before age 60
- ☐ Abnormal MSI/IHC tumor test result (colon/rectal/endometrial/uterine)
- ☐ Two or more Lynch syndrome cancers**at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndromes

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, either in one relative or in two or more relatives on the same side of the family
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome**(see cancer list below)

- ☐ Two or more relatives with a Lynch syndrome cancer,** one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age

BOC associated cancer includes: Breast, ovarian, and pancreatic cancer
Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas
MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For MD/Lab Use Only: Patient offered hereditary cancer genetic testing? YES / NO ACCEPTED / DECLINED

Lab initials (if tested day): **If not tested today, schedule follow-up for genetic test?** YES / NO

REGIONAL CANCER CARE ASSOCIATES LLC
CONSULTATION CHECKLIST

In an effort to ensure you receive the most comprehensive care and enable us to provide you with a thorough evaluation, RCCA prefers having your records for review ***prior*** to the time of your appointment, and would appreciate your faxing or delivering them to our office. If you are unable to do so in advance, we request you bring the following records to your appointment. If we do not have your records at the time of your visit, we will need to reschedule your appointment. These records include:

- Medical records from other physicians. If you are currently undergoing treatment of any kind, RCCA needs the "flow sheet" prepared by your current physician. This will note the types of treatment you are receiving, along with the dosages.
- All hospital records (histories, physicals, lab reports, treatment records, discharge summaries and consultations).
- The original CDs of all x-rays, MRIs or scans, along with the radiologist's reports.
- The pathology and operative reports of any biopsies or surgeries. These materials can be obtained from the Pathology Department of the facility where the procedure was performed.

CHECKLIST

For your convenience, below is a checklist of items needed for your visit:

_____ *All Pages* of this RCCA Patient Information Packet Completed and Signed

_____ Insurance Card(s)

_____ Prescription Plan Card

_____ Photo ID

_____ Referral (if required)

_____ X-ray, MRI, CT, PET, CDs and Reports

_____ Pathology Reports

_____ Laboratory Test Reports

REGIONAL CANCER CARE ASSOCIATES LLC
CENTRAL JERSEY DIVISION BILLING POLICY

Regional Cancer Care Associates (RCCA) participates with most major insurance carriers and will work diligently as your patient financial advocate in an effort to help you understand and access your benefits. Please contact your insurance carrier to confirm that we participate with them and be sure to *bring your insurance cards every time* you come to the office. Also, make sure to inform our staff whenever you have a change of insurance.

For your peace of mind, RCCA maintains firm policies and procedures on cost containment and ethical billing practices. Operating in compliance with the Health Insurance Portability and Accountability Act (HIPAA), RCCA protects and secures your health information and privacy, ensuring that all of your information will remain confidential.

As a participating provider with your insurance carrier, we are contractually obliged to collect co-pays at the time of service. You insurance company may require co-pays, not only for office visits with your physician, but also for chemotherapy treatments, injections and laboratory appointments. We must collect co-pays at the time of service for these visits as well. Upon completion of your visit and payment of your co-pay, RCCA will bill your insurance company for the remaining balance due. In the event you are unable to pay the co-pay at the time of your visit, we regret we will be unable to accommodate you and your appointment will need to be rescheduled.

In the event that RCCA is not a participating provider with your insurance company, we will still forward your billing claims to your insurance company at the time of your visit. RCCA will then bill you for any remaining charges not covered by your insurance company. You will be responsible for this remaining balance.

Patients without any insurance must be prepared to make a full payment at the time of service.

Med-Metrix is responsible for handling patient billing at RCCA's Central Jersey Division. Med-Metrix representatives are available Monday thru Friday from 8:00am - 4:00pm to work with you on any questions or concerns you may have and can be reached at 1.800.220.8369.

If your insurance requires referrals, it is your responsibility to ensure the referral is either sent to our office prior to your visit or you may also bring it with you to your appointment. We suggest that you retain a copy so that you may keep track of the number of visits left on your referral and its expiration date. Please feel free to ask RCCA to make a copy of your referral for you. We may have to reschedule your visit if you do not have a current referral on file.

If you are unable to make your appointment at RCCA, it is important to call us to cancel the appointment a minimum of 24 hours in advance. In the event you do not call us to cancel, we regret we must charge a fee, as we have reserved this time for you.

RCCA will bill patients on a monthly basis for the balance of charges not covered by their insurance companies. RCCA requests payment of any balance due within sixty days of the date of the RCCA bill. After sixty days, balances due will be billed at a rate including an additional 1.5% interest fee per month. RCCA accepts payments in the form of cash, check or credit card.

REGIONAL CANCER CARE ASSOCIATES LLC
FREQUENTLY ASKED QUESTIONS

What will occur during my initial visit?
Your physician consultation will generally consist of a physical examination, discussion of medical history and diagnosis, probable plan of care, as well as time for any questions you may have. Initial consultations generally last about an hour to an hour and a half. It is necessary to have your medical records forwarded to our office in advance of your appointment so your Regional Cancer Care Associates physician may review them prior to your visit.

Will I have any testing done while I'm in the office?
Your physician may order some Laboratory testing (blood work) upon the completion of your consultation. This may be completed in our Labs. Other diagnostic tests, such as scans or x-rays, may be ordered and scheduled for a later date at the appropriate location (these diagnostic tests are not completed in our offices).

Will I start chemotherapy treatment the same day as my consultation?
Chemotherapy treatment will not begin the same day as your consultation. Chemotherapy often requires additional testing such as scans and biopsies before the treatment begins. It is also necessary to have your health insurance company authorize chemotherapy in advance (this generally takes approximately one week) to ensure that your treatment will be covered by insurance. The timing of initial chemotherapy treatments varies on a case by case basis. After your physician has obtained any required test results and your insurance company has authorized the treatment, you will receive a call from the RCCA nursing staff to schedule your treatment. You will begin with a detailed one-on-one chemotherapy education session with one of our nurse practitioners or oncology nurses. This session will provide you with information about your specific treatment and allow you to ask any questions you may have.

Where will I receive chemotherapy treatment?
Many of our patients receive chemotherapy here in our offices. Our oncology nurses are trained in the administration of the latest chemotherapy treatments. Occasionally, due to insurance reasons, we will schedule our patients for their treatment on an out-patient basis at one of the hospitals where our physicians have privileges.

I need to see a hematologist and understand RCCA physicians treat not only oncology (cancer) patients, but also hematology (blood) disorders. Can you please explain?
Our physicians are not only board-certified in oncology, but hematology as well. Our physicians have extensive knowledge and experience in the diagnosis and treatment of diseases of the blood, ranging from anemia to clotting problems. We treat many hematology patients with non-cancerous blood disorders. (It is very common for oncologists to also practice hematology, as many of the side effects of chemotherapy are blood related, for example, anemia and neutropenia.)

What hospitals are RCCA affiliated with?
We are affiliated with JFK Medical Center in Edison, NJ; Robert Wood Johnson University Hospitals in New Brunswick, Rahway and Somerville, NJ; and Saint Peter's University Hospital in New Brunswick, NJ. We are not able to treat patients at other hospitals, as we are not on staff.

I am aware that I will require chemotherapy treatment and am concerned about the co-payments. Are there any assistance programs available?
In the event that you will be receiving chemotherapy treatments, our billing department may contact you prior to your first treatment to discuss assistance programs that are available. In cases of need, we will discuss your options regarding assistance from several organizations.