CENTRA
Alan B. Pearson
Regional Cancer Center

1701 Thomson Drive
Lynchburg, Virginia 24501

PHONE: 434.200.4522
WEB: www.centrahealth.com

Dear Patient,

Welcome to our practice! At Centra Lynchburg Hematology Oncology, our patients are at the center of everything we do. Putting you first with expert care and long-lasting partnerships is our life's work. We thank you for trusting us with your healthcare needs, and we look forward to seeing you.

We invite you to visit our new patient welcome page, www.CentraHealth.com/CancerCenterWelcome, where you can find frequently asked questions and other resources.

To prepare for your visit, below please find your appointment details and other pertinent information.

1) Appointment – Your current appointment is on_____

at _____ with _____. You were referred to our office by _____ for _____.

2) Completed Forms – Please complete the enclosed forms bring them with you to your appointment.

3) Location – Our office is located in the Alan B. Pearson Regional Cancer Center at 1701 Thomson Drive in Lynchburg, VA, near Lynchburg General Hospital. You can park and enter through the main entrance at the middle of the building, where you will be welcomed by our receptionists in the main lobby.

4) Important Billing Information – On the day of your appointment you will be asked to provide your insurance details, contact information and sign any required forms. Please bring the following:

- ☐ Your Photo ID
- ☐ Insurance cards and copayment, if applicable
- ☐ Current medication list or original bottles (including prescriptions, hospital discharge medications and instructions, over-the-counter, supplements and herbal medications). "My Medicine List" is enclosed in this packet for your convenience.
- ☐ Enclosed completed forms.
- ☐ If your visit requires a referral or pre-authorization, please coordinate with your insurance carrier(s) or your primary care provider's office to make sure these tasks are complete.

If you have medical records that should be transferred to us, please contact our office about signing a records release. It is very important for us to obtain this information before your appointment.

We are looking forward to participating in your care. If you have any questions prior to your appointment, please give us a call at (434)200-5925.

Sincerely,
Centra Lynchburg Hematology Oncology
Alan B. Pearson Regional Cancer Center

☐ Centra Lynchburg Hematology Oncology
1701 Thomson Drive, Suite 200
Lynchburg, Virginia 24501
Phone: 434-200-5925 Fax: 434-485-7840

☐ Centra Southside Hematology Oncology
800 Oak Street
Farmville, Virginia 23901
Phone: 434-315-2690 Fax: 434-315-2697

New Patient Worksheet

Please bring this form with you on your first visit

Name:_____

Date of Birth:_____

Phone Number:_____

Address:_____

_____

Email Address:_____

Primary Care Physician:_____

Other Physicians you see:

_____

_____

Illnesses and Injuries with dates:

_____

_____

_____

_____

_____

_____

Past Surgeries with dates:

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

_____

_____

Patient Label

Emergency Contact:_____

Relationship to Patient:_____

Emergency Contact Phone Number:_____

Marital Status:_____

Occupation:_____

Tobacco:

☐ Yes / ☐ No

Packs per day:_____ Years_____

Alcohol:

☐ Yes / ☐ No Types:_____

Amount per day:_____ Years_____

Any illnesses that run in the family_____

_____

_____

_____

Relatives with cancer or blood problems:

Father_____

Grandfather_____

Grandmother_____

Mother_____

Grandfather_____

Grandmother_____

Brothers and sisters_____

Children_____

_____

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Family Cancer History

Please fill out the form below if you or your family members have had a cancer. Be sure to mark the cancer type, list the approximate age when diagnosed and if they passed away from cancer.

	Breast Age	Colon Age	Colon Polyps Age	Melanoma Age	Ovary Age	Pancreas Age	Stomach Age	Uterus Age	Other Age	Deceased Y or N
YOU										
Mother										
Father										
Sons										
Daughters										
Brothers										
Sisters										
Nieces										
Nephews										
Mother's Side										
Grandmother										
Grandfather										
Aunts										
Uncles										
Cousins										
Father's Side										
Grandmother										
Grandfather										
Aunts										
Uncles										
Cousins										

This data will be reviewed by clinical providers to determine if additional information is required or if it is recommended for you and your family members to have genetic testing. Genetic testing is a blood test to determine if you or a family member have an inherited tendency to develop cancer. The office staff will contact you to set up additional appointments if needed.

Name:_____

Date of Birth:_____

Office notes: _____

_____

Patient Label

CENTRA

Name: _____ Date of Birth: _____

My Medicine List

What I'm Using (Name of the medicine – generic and brand name)	**What it Looks Like** (Color, shape, size, markings, etc.)	**How Much** (Dosage, amount, etc.)	**How to Use & When to Use**	**Start/ Stop Dates**	**Why I'm Using** (Notes about my medicine)	**Who Told Me to Use It** (Who Prescribed This Medicine)
Enter ALL prescription (Rx) medicine (including samples), over the counter (OTC) medicines and supplements/vitamins						

Bring this list with you to EVERY visit. Keep it up to date with all new medicines.

Bring to all other doctor visits, and drug store. Write down all new medications or dose changes.

Be sure to carry the list with you at all times in case of an emergency.

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Date: _____

Name: _____

Date of Birth: _____

Depression/Emotional Problems Screening

Over the past two weeks have you experienced:

Little interest or pleasure in doing things	**Yes_____**	**No_____**
Feeling down, depressed, or hopeless	**Yes_____**	**No_____**
Thoughts of harming yourself or others	**Yes_____**	**No_____**

Which statement below describes your energy level? Choose one.

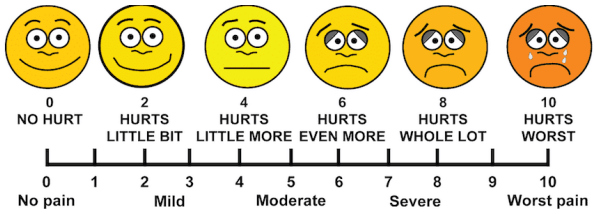
- ☐ **Fully able to carry on all pre-disease activities without restriction**
- ☐ **No physically strenuous activity, but ambulatory and able to carry out light house or office work.**
- ☐ **Ambulatory, capable self-care, unable to perform any work activities (50% or more of the day)**
- ☐ **Capable of limited self-care, confined to a bed or wheelchair (More than 50% of waking hours)**

Please mark current problems below:

☐ **None of the problems mentioned below**

Please rate pain:_____

Location:_____



General
- ☐ Anxiety
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Sleep Apnea
- ☐ Weight loss

Date of Flu Vaccine:

_____

Eyes
- ☐ Blurred/ Double vision

Ear/Nose Mouth/Throat
- ☐ Dentures
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Mouth dryness
- ☐ Mouth sores
- ☐ Nosebleed
- ☐ Ringing ears
- ☐ Swallowing Pain/Trouble
- ☐ Taste altered
- ☐ Tooth problems

Neck
- ☐ Masses
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling

Skin
- ☐ Changing Moles
- ☐ Dry skin
- ☐ Hair loss
- ☐ Itching
- ☐ Rash

Arms
- ☐ Swelling/Fullness

Breasts
- ☐ Breast masses
- ☐ Breast swelling
- ☐ Nipple discharge
- ☐ Nipple inversion

Heart / Circulation
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Irregular heart beat
- ☐ Pacemaker / Defibrillator
- ☐ Palpitations

Respiratory / Lungs
- ☐ Cough
- ☐ Coughing up blood
- ☐ Coughing up mucus
- ☐ Breathing problems
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black or bloody stools
- ☐ Constipation
- ☐ Diarrhea / Loose stool
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

Urine / Genital/ Sexual
- ☐ Blood in urine
- ☐ Urgency or burning
- ☐ Decreased sexual function
- ☐ (MEN) Erection Difficulty
- ☐ Loss of urine control
- ☐ Pain with sex
- ☐ Urinating at night
- ☐ Urinating > every 2hours
- ☐ Change in urine color

Female Only
- ☐ Vaginal discharge or bleeding

Is there a possibility that you could be pregnant?

Yes ☐ No ☐ Initials:_____

Musculoskeletal
- ☐ Bone pain
- ☐ Joint pain or swelling
- ☐ Muscle weakness
- ☐ Stiffness

Neurologic
- ☐ Balance problem
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness of hands or feet
- ☐ Seizure
- ☐ Tingling

Hormone
- ☐ Hot flashes

Blood / Lymphatic
- ☐ Easy bruising
- ☐ Swollen lymph glands

Tobacco Use
- ☐ No
- ☐ Yes / How many daily_____

Alcohol Use
- ☐ No
- ☐ Yes / How many daily_____

Other problems:

_____

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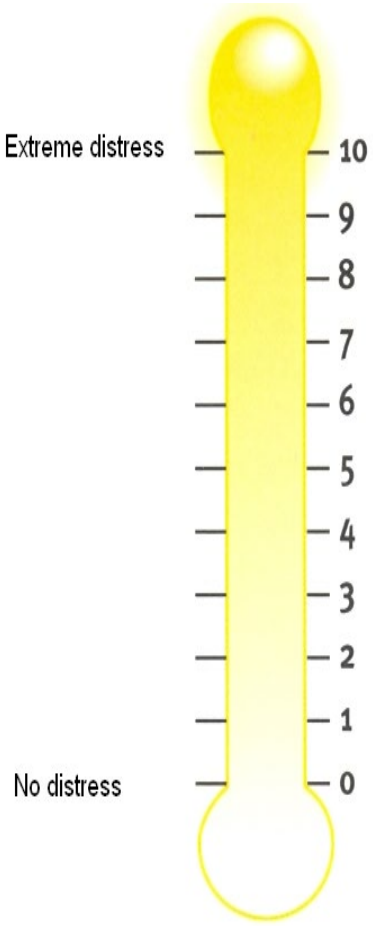
Date: _____

Name: _____

Date of Birth: _____

First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



YES	NO	Practical Problems
☐	☐	Child Care
☐	☐	Food
☐	☐	Housing
☐	☐	Insurance/Financial
☐	☐	Transportation
☐	☐	Work/School
☐	☐	Treatment decisions

YES	NO	Family Problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues

YES	NO	Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities

☐	☐	**Spiritual/religious concerns**

YES	NO	Physical Problem
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling Swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/itchy
☐	☐	Sleep
☐	☐	Substance Abuse
☐	☐	Tingling in hands/feet

Other Problems:

_____

_____

_____

_____

Sharing Medical Information

Sharing medical information with others for their involvement in your health care treatment or payment.

Shared Information: Please list below the person(s) with whom we may share your medical information. By listing any person(s) below in the chart, you agree that Centra may release your medical information that is directly relevant to your health care or payment. Centra is entitled to rely on the representation of any person you list that the medical information being requested is relevant to his/ her involvement in your health care or payment for health care. If the below chart is left blank, Centra will not share your medical information by virtue of this form.

Name	Relationship	Telephone	CMG/ Centra Locations
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:
			☐ All Locations or ☐ Specific Location:

Signature **Date/Time**

☐ **Parent or Legal Guardian** ☐ **Power of Attorney** ☐ **Next of Kin/ Deceased** ☐ **Administrator of Estate**

Patient Label

Place Patient Label Here

Centra Financial Assistance Application

Dear Patient,

Enclosed is a financial assistance application for you to review. If you choose to complete, please follow the instructions below to avoid any processing delays.

- We will need supporting documents to process the application. Please include the following:
  - Current Social Security Award Letter
    - For patient and spouse
  - Proof of income for any wages other than social security
    - If working, please provide one month of pay stubs
    - Unemployment Statement
    - Retirement or Pension Statement
    - Previous year Tax Return / W-2 (Only if Self Employed)
  - Copy of the most recent bank statement
    - ALL PAGES
      - EX. If page 1 states “page 1 of 6”, all 6 pages will be required even if they are blank
- Once complete, return the application to our office
  - Fax: 434-200-6278 Attn: Krystle
  - Email: PCCPatientSupport@centrahealth.com
  - Mail: 1701 Thomson Drive
    Attn: Krystle Overstreet
    Lynchburg, VA 24501

Feel free to call our office if you have any questions, 434-200-1422.

Thank you,
Krystle Overstreet
Financial Navigation

Centra
Application For Financial Assistance
CONFIDENTIAL

Dear Valued Patient:

If you are in need, Centra wants to help you with understanding your bill. For those who may not have health insurance or other ways to pay for their care, we offer several options for assistance. Because we promise to care for our community, our programs provide assistance for those who meet certain financial levels.

Patients who have income at or below 133% of the federal poverty level may qualify for full assistance. Patients with income between 200% and 400% may qualify for discounts based on the amount owed.

If you have questions call 434-200-3777 to speak with a customer service staff member. You may also complete Centra's Financial Application and mail it to the business office.

STEP 1: Complete patient information. Please fill out all information concerning the patient completely.
STEP 2: Fill out income and asset information. This includes income from your employer, social service aid (food stamps, ADC), government aid (social security, VA benefits), and all other income. If any child is 18 years or older, a separate form is required.
STEP 3: Fill out monthly expenses. This includes mortgage payment, rent, utilities, loans, medical, or other expenses.

Please determine which types of documentation below may apply to your situation: (Send copies only. Originals will not be returned).

- **PAY CHECK STUBS:** If you are employed, you must provide one month's worth of your pay check stubs, not more than three months old. If your stubs are not available, you need to provide a letter from your employer stating one month's salary.
- **UNEMPLOYMENT:** Forms verifying weekly benefits.
- **SELF EMPLOYED:** Provide your current year Federal Income Tax return, including all schedules.
- **OTHER RESOURCES:** Retirement benefits, General Relief check, ADC check, trust fund allotments, child support check and alimony.
- **GOVERNMENT BENEFITS:** Letter confirming or denying Social Security, SSI, VA or other government benefits, copy of check(s) or bank statement showing automatic deposit.
- **SOCIAL SERVICES:** Approval, denial, or pending status from your local department of social services. Any letters confirming receipt of housing and/or food stamps monthly benefit amount.
- **BANK STATEMENTS:** Most recent savings and/or checking account statement(s) from the bank or credit union.
- **SICK LEAVE:** Statement from doctor stating dates you are unable to work. Statement from employer indicating paid sick leave or if you are on leave without pay, year to date gross and hire date.
- **LETTER OF SUPPORT:** Letter verifying support from family or friends (when no income is reported or not enough to show support)
- **STUDENTS:** Scholarship, loan, workstudy, stipend, tuition, or grant award amounts.

STEP 1: COMPLETE INFORMATION BELOW:

Patient Name:	Soc Sec #:	
Address:	Birth Date:	
City, State, Zip:	Phone #:	Medical Record #:

STEP 2: FILL OUT INCOME / ASSET INFORMATION *If there is no reported income, explain your means of financial support.
Who is head of household? *This is the member of the family who provides food and shelter for the applicant. The applicant may be the head of the household. A nonfamily member should not be listed in the family section.*

Family Members - include self and claimed dependents in household	Age	Relation to head of household	Gross monthly income (pretax)	Employer Name	Employer Phone #

If patient or head of household is unemployed, please provide the date employment was terminated:_____

Patient Label

PLEASE MAIL COMPLETED FORM TO:
Attention: Customer Service
Centra Patient Accounting Services
PO Box 2496
Lynchburg, Virginia 24505-2496

STEP 2: INCOME / ASSETS, CONTINUED

Do you have Medicaid? Yes / No *If yes, please provide a copy of your Medicaid card.

Have you ever applied for Medicaid? Yes / No *If yes, please list where and when:_____

Checking Acct? circle: Yes / No **Acct Number:**	**Bank Name:** **Location:**	**Balance: $**
Savings Acct ? circle: Yes / No **Acct Number:**	**Bank Name:** **Location:**	**Balance: $**
Investments? circle: Yes / No *Stocks, Bonds, IRA's, 401K / 403B, CD's etc.*	**Bank Name:** **Location:**	**Balance: $**

Real Estate Property? circle: Yes / No **Address:**	**Rent / Buy** *circle one*	**Total acreage:**	**Monthly Payment: $**
Real Estate Property? circle: Yes / No **Address:**	**Rent / Buy** *circle one*	**Total acreage:**	**Monthly Payment: $**

Taxable personal property: (circle one) Yes / No (list cars, boats, trucks, motorcycles, campers, mobile homes, etc.)

Item:	**Make** **Model:**	**Year:**	**Amount Owed: $**	**Value: $**
Item:	**Make** **Model:**	**Year:**	**Amount Owed: $**	**Value: $**
Item:	**Make** **Model:**	**Year:**	**Amount Owed: $**	**Value: $**

Do you have a life insurance policy for you or any dependent over 21 with a cash-in value over $1,500 (circle one)? Yes / No

Name of ins. co:_____ **Policy #:**_____ **Cash-in value? $**_____

Are you currently working with an attorney or insurance carrier on an accident claim (circle one)? Yes / No

_____

Name of Attorney or insurance company Telephone Number Date of Accident / Claim Number

STEP 3: FILL OUT EXPENSES & LIABILITIES INFORMATION

Mortage / Rent	**$**	**Electrical**	**$**
Transportation (loan / gas amt)	**$**	**Other utilities:** (telephone, cable, water, etc)	**$**
Food	**$**	**Medical** (include prescription)	**$**
Loans	**$**	**Credit Cards** (total)	**$**
Other expenses	**$**		**$**
		Total Monthly Expense, all columns	**$**

IN ORDER FOR CENTRA TO COMPLY WITH STATE GUIDELINES, EACH OF THE ITEMS YOU HAVE LISTED ON THIS APPLICATION WILL REQUIRE DOCUMENTATION. PLEASE DO NOT SEND IN YOUR APPLICATION UNLESS YOU HAVE ATTACHED ALL NEEDED ITEMS. RETURN INFORMATION PROMPTLY OR YOU WILL BE RESPONSIBLE FOR YOUR FULL CHARGES.

THE INFORMATION PROVIDED IS TO THE BEST OF MY KNOWLEDGE COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION NEEDED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH CENTRA'S FINANCIAL AID PROGRAM OR OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF ANY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INSURANCE POLICY, STOCKS, OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, I AUTHORIZE CENTRA TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

***SIGNATURE(S) REQUIRED**

Applicant's signature:	**Date / Time:**
Spouse's signature:	**Date / Time:**

Patient Label

CENTRA
Alan B. Pearson
Regional Cancer Center

Cancer Center Database

The Centra Alan B. Pearson Regional Cancer Center continues to develop a database to allow us to more effectively and efficiently communicate with you. This database is simply an electronic list of individuals interested in receiving information from the Cancer Center. We are also interested in receiving feedback from you to continuously improve our services here at the Cancer Center.

This database is confidential and will not be shared in any way. Only authorized staff members of the Centra Alan B. Pearson Regional Cancer Center will have access to the database.

By adding your name to this confidential database, you will receive information about: educational materials, community events, support groups, fundraisers, newsletters, exercise and nutrition programs.

Contact Information:

Name: _____
Street Address: _____
City, State, Zip: _____
E-mail Address: _____

I agree to have the above contact information included in the Centra Alan B. Pearson Regional Cancer Center database.

Signature: _____
Date: _____