



Dear Patient,

Welcome to our practice! At Radiation 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, a tour of our facility and other resources.

1) Appointment – Your current appointment is on _____ at _____ with _____.

2) Completed Forms – Please complete the enclosed forms and 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.

5) Insurance Information – You will be called prior to your appointment by our registrar and asked to provide your insurance information. Please note that there are certain insurance providers that our private practice providers do not participate with (see enclosed list).

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. Following your appointments you will receive **two bills**, a bill from Centra as well as a bill from our private practice physicians, Radiation Oncology Associates. 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)200-4010.

Sincerely,
Radiation Oncology
Centra Alan B. Pearson Regional Cancer Center



Insurance Providers that Radiation Oncology Associates participate with:

Medicare (all Advantage Plans)

Medicaid

VA Premier-Medicaid Only

Optima-HMO

Optima Medicaid

Anthem (BCBS)

Cigna

Aetna Better Health (Medicaid)

BWXT- Energy Employees Occupational Insurance

PACE (A Program of All-inclusive Care for the Elderly)

Piedmont Community Health Plan (PCHP)

United Healthcare

Humana

Please contact our office prior to your appointment if your insurance provider is not one of these listed. Also, if your insurance changes at any point while you are a patient with us, please provide us with your new insurance information as soon as you have this information.

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
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:
			<input type="checkbox"/> All Locations or <input type="checkbox"/> Specific Location:

Signature

Parent or Legal Guardian

Power of Attorney

Next of Kin/ Deceased

Date/Time

Administrator of Estate

Patient Label

Place Patient Label Here



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.



CENTRA

Alan B. Pearson
Regional Cancer Center

Date: _____

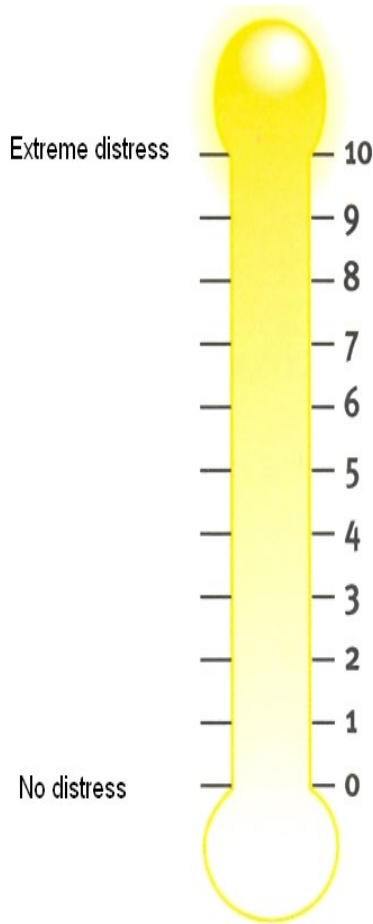
Name: _____

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.

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

We want this to be an accurate rating of how you are feeling the day of your appointment. Please fill out the morning of your appointment!



YES	NO	Practical Problems
<input type="checkbox"/>	<input type="checkbox"/>	Child Care
<input type="checkbox"/>	<input type="checkbox"/>	Food
<input type="checkbox"/>	<input type="checkbox"/>	Housing
<input type="checkbox"/>	<input type="checkbox"/>	Insurance/Financial
<input type="checkbox"/>	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	<input type="checkbox"/>	Work/School
<input type="checkbox"/>	<input type="checkbox"/>	Treatment decisions

YES	NO	Family Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner
<input type="checkbox"/>	<input type="checkbox"/>	Ability to have children
<input type="checkbox"/>	<input type="checkbox"/>	Family health issues

YES	NO	Emotional Problems
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Fears
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Sadness
<input type="checkbox"/>	<input type="checkbox"/>	Worry
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in usual activities

<input type="checkbox"/>	<input type="checkbox"/>	Spiritual/religious concerns
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YES	NO	Physical Problem
<input type="checkbox"/>	<input type="checkbox"/>	Appearance
<input type="checkbox"/>	<input type="checkbox"/>	Bathing/dressing
<input type="checkbox"/>	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Changes in urination
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Feeling Swollen
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Getting around
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Memory/concentration
<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Nose dry/congested
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sexual
<input type="checkbox"/>	<input type="checkbox"/>	Skin dry/itchy
<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/feet

Other Problems:



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.

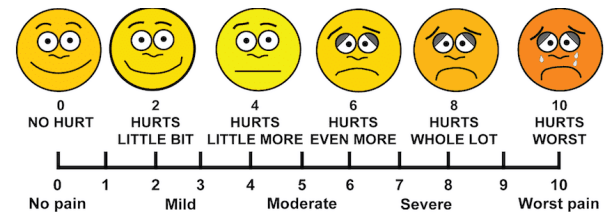
- Fully able to carry on all pre-disease activities without restriction
- No physically strenuous activity, but ambulatory and able to carry out light house or office work.
- Ambulatory, capable self-care, unable to perform any work activities (50% or more of the day)
- Capable of limited self-care, 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: _____

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

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

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: _____

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 also include the following:
 - Current Social Security Award Letter
 - For patient and spouse
 - Proof of income for any wages other than social security
 - If no social security, please submit the most recent tax return
 - 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

COPY

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

Application For Financial Assistance
 Centra #999-3427
 REV 03/29/17
 Page 1 of 2



**Centra
Application For Financial Assistance**

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 <i>Stocks, Bonds, IRA's, 401K / 403B, CD's etc.</i>	Bank Name: Location:	Balance: \$

Real Estate Property? circle: Yes / No Address:	Rent / Buy <i>circle one</i>	Total acreage:	Monthly Payment: \$
Real Estate Property? circle: Yes / No Address:	Rent / Buy <i>circle one</i>	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

Mortgage / 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

COPY