NEW PATIENT

PREPARATION PACKET

WELCOME

Dear New Patient,

We would like to make your experience at The Urology Cancer Center as convenient as enjoyable as possible. Please fill out the attached new patient packet and bring it with you, along with your photo ID, primary, secondary, and prescription insurance cards to your appointment.

During your consultation, Dr. Nordquist's education is both extensive and thorough so we ask that you have family members and/or close friends accompany you to your appointment. It is extremely beneficial to have someone by your side to listen to the information, take notes, and most importantly, provide support for you!

We are looking forward to meeting you!

Sincerely,

The Urology Cancer Center

WHAT TO EXPECT

HERE IS WHAT YOU SHOULD PREPARE FOR PRIOR TO YOUR FIRST VISIT AT THE UROLOGY CANCER CENTER

Our new patients are incredibly important to us. We value every patient's experience and make your comfort our top priority.

ARRIVE EARLY

Plan to arrive 30 minutes early so our team can check you in, finish your registration, and give you a tour of our facility.

PLAN TO STAY AWHILE

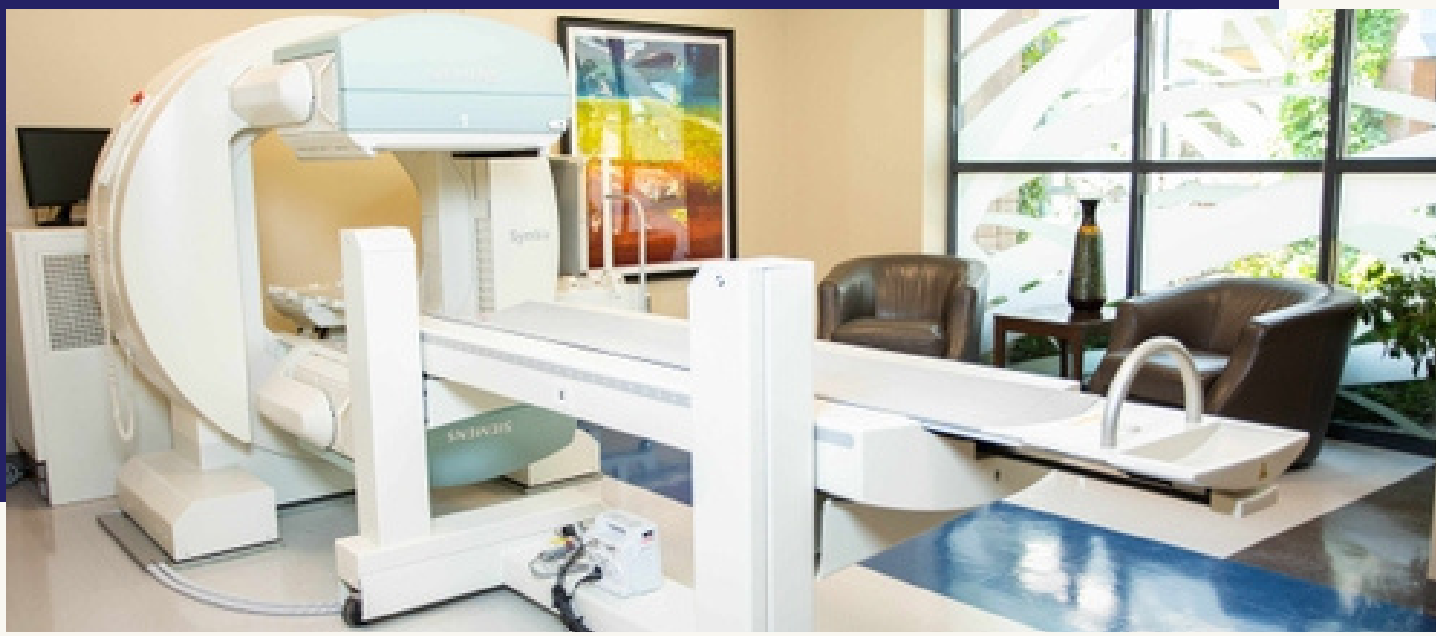
Patient relationships and education are among our top values. Dr. Luke spends on average 2 hours with every new patient educating and answering questions to ensure a thorough understanding of treatment options.

BRING YOUR SUPPORT SYSTEM

The more the merrier! Truly! Dr. Luke wants to make sure he has the opportunity to not only go over concerns with your whole family but get to know the people you count on.

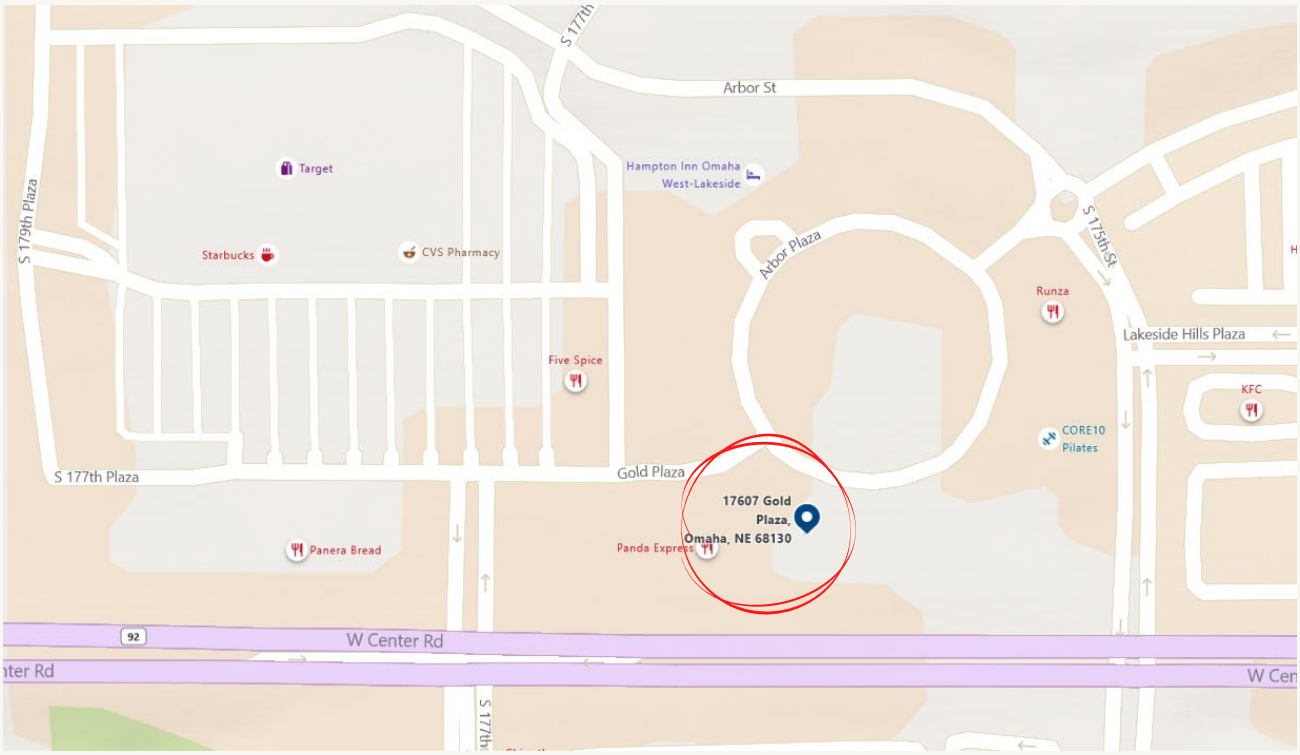
CALL US ANYTIME

We are happy to answer any questions you might have prior to your visit. Please don't hesitate to call.



HOW TO FIND US

WE ARE LOCATED OFF 176TH AND CENTER CADDY CORNER TO TARGET AND TO THE LEFT OF PANDA EXPRESS. OUR MAIN ENTRANCE FACES SOUTH.



HOW TO REACH US

Office Hours: M - TH 8:00am - 5:00pm CST & F 8:00am - 2:30pm CST

Address	17607 Gold Plaza Omaha, NE 68130
Phone	402-991-8468
Fax	402-991-8469
Website	www.gucancer.com

Patient Information

Legal Patient Name: _____
(First) (Middle) (Last)

Preferred Name: _____

Date of Birth: _____

Maiden Name: _____

Address: _____

_____
City State Zip

Gender: Male / Female

Place of Birth: _____
City State

Social Security Number: _____

For Patients that Identify in the LGBT Community:

Gender Identity: Male, Female, Non-Binary

Orientation: L G B T

Home Phone: (____)_____

Is it ok to leave a message? ☐ YES ☐ NO

Mobile Phone: (____)_____

Is it ok to leave a message? ☐ YES ☐ NO

Work Phone: _____

Is it ok to leave a message? ☐ YES ☐ NO

Which phone would you prefer to be contacted at?

☐ HOME ☐ CELL ☐ WORK

Email Address: _____

Patient Demographics

Marital Status: ☐ Married ☐ Single

☐ Divorced ☐ Separated

☐ Widowed ☐ Domestic Partner

Race: ☐ White ☐ Black or African America

☐ Asian ☐ Native Hawaiian/ Other Pacific Islander

☐ Other

Ethnicity: ☐ Hispanic or Latino

☐ Non-Hispanic or Latino

☐ Declined to specify

Language Preferred: ☐ English ☐ Spanish ☐ Other

Employee Status: ☐ Full Time ☐ Part Time

☐ Retired ☐ Other

*If Working Full Time or Part Time:

Employer Name: _____

Patient Referral Information

☐ Self Referred (Please Check how you heard about us below)

☐ Friend/Family ☐ Radio

☐ Newspaper Article ☐ Airport Media

☐ Other _____

☐ Referring MD: _____

Other Current Physicians (This includes all current Specialists and/or Family Practice Physicians):

Name Specialty

_____

_____

_____

_____

Responsible Party Information

☐ Responsible Party is same as Patient Information

*Please fill out the following if information is different than Patient Information

Subscriber Name: _____
First Last

Subscriber Address: _____

_____
City State Zip

Subscriber Date of Birth: _____

Subscriber Social Security #: _____

Home Phone: (___) _____

Mobile Phone: (___) _____

Work Phone: (___) _____

Patient Insurance Information

*Please provide insurance cards, photo ID and prescription cards to the receptionist

Primary Insurance: _____

Secondary Insurance: _____

Prescription Drug Plan: _____

Patient's Preferred Pharmacy

Name: _____

Address: _____

_____
City State Zip

Pharmacy Phone: (___) _____

Medicare Required Questions

*Are you covered by Medicare? ☐ YES ☐ NO

(If **YES** please complete the following questions. If **NO** skip to next section.)

Are you or your spouse employed? ☐ YES ☐ NO

If yes, do you have group health coverage through an employer? ☐ YES ☐ NO

Are you entitled to Medicare because of Disability or End State Renal Disease? ☐ YES ☐ NO

Is this illness or injury the result of an automobile accident or other injury? ☐ YES ☐ NO

Is this illness or injury the result of an accident or illness that occurred at work? ☐ YES ☐ NO

Has treatment and payment been authorized by the Veteran's Administration? ☐ YES ☐ NO

Are you entitled to any benefits under the Federal Black Lung Program? ☐ YES ☐ NO

Acknowledgment

To the best of my knowledge, all the information provided is true and accurate.

Name of Patient: (Please Print)

_____

Patient Signature:

_____ Date: _____

Living Will/POA

Do you have a living will? ☐ YES ☐ NO

Do you have a Power of Attorney? ☐ YES ☐ NO

If yes who is your POA? _____

Emergency Contact Information

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Alternate Emergency Contact (Optional)

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Alternate Emergency Contact (Optional)

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Alternate Emergency Contact (Optional)

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Alternate Emergency Contact (Optional)

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Alternate Emergency Contact (Optional)

Emergency Contact: ______________________________
(First Name) (Last Name)

Relationship: ______________________________

Emergency Contact Phone: (____) ______________

Alternate Phone: (____) ______________

*Permission to release information to Emergency Contact? ☐ YES ☐ NO

Today's Date:_____

Patient Name:_____
(First Name) (Last Name)

Date of Birth:_____

Medication (Please include herbs and over-the-counter)	**Dose (mg, ml, etc)**	**Frequency (how many times/day)**	**Reason for taking the medication**	**Year Started Taking Med**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies

Do you have any known allergies? □ No □Yes

List all known allergies:_____

Family History

Please check each medical condition that has occurred in your blood relatives:

DISEASE	Father	Mother	Sister	Brother
Diabetes				
Kidney Disease				
Kidney Stones				
Cancer				
Bleeding Tendency				
High Blood Pressure				
Heart Disease				
Nervous Disorder				
Stroke				
Tuberculosis				

Is your Father alive? ____ Yes ____ No Age/Age at death:____
Genetic Relationship: ____ Natural ____ Half ____ Neither
Present Health or Cause of Death:_____

Is your Mother alive? ____ Yes ____ No Age/Age at death:____
Genetic Relationship: ____ Natural ____ Half ____ Neither
Present Health or Cause of Death:_____

If you have siblings are they alive?
(list out of mulitiple siblings) ____ Yes ____ No

Age/Age at death:____ Present Health or Cause of Death:_____
Age/Age at death:____ Present Health or Cause of Death:_____
Age/Age at death:____ Present Health or Cause of Death:_____
Age/Age at death:____ Present Health or Cause of Death:_____

If you know of any other medical conditions that run in your family please list them here:

_____
_____

Patient Name:_____

Patient DOB:_____

Insurance Requirement

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____+_____+ _____

=Total Score: _____

If you checked off any problems, how difficult have these problems 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**
☐	☐	☐	☐

Fax Cover Sheet

Authorization for Release of Medical Records

Urology Cancer Center
17607 Gold Plaza
Omaha, NE 68130
Phone: 402-991-8468
Fax: 402-991-8469

Please fax with the attached medical records as requested below to Urology Cancer Center

To: Urology Cancer Center

Fax: 402-991-8469

Page Count: .....

FROM:

Medical Facility: .....

Physician: .....

Phone: .....

Date: .....

Regarding Patient Name: .....

Patient DOB: .....

I, the undersigned, hereby authorize (physician & clinic) .....

_____ To disclose the following personal health information for the purpose of scheduling a consultation visit by self-referral:

- All surgical pathology results from all biopsies and surgical procedures pertaining to my cancer;
- All laboratory results pertaining to my cancer;
- All prior treatment records including any systemic therapies, radiation treatment records, cryotherapy, clinical trials, or other pertinent therapies;
- All radiographic reports which are pertinent to my cancer;
- All physician notes pertinent to my cancer; including notes relating to the testing, diagnosis and/or treatment for HIV (AIDS virus; sexually transmitted diseases; mental health; drug and/or alcohol abuse.

PATIENT AUTHORIZATION:

Patient Name .....

Patient Signature _____ **Date:** _____

This authorization shall expire one year from the date written above. I understand that I have the right to revoke this authorization at any time by providing my Health Care Provider with written notice of such revocation, sent by certified mail, fax, or hand delivery. I further understand that any revocation shall not be effective as to information already disclosed pursuant to this authorization.

17607 Gold Plaza | Omaha, NE 68130
Tel: 402.991.8468 | Fax: 402.991.8469
www.xcancer.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices of Urology Cancer Center, P.C. d/b/a XCancer, in effect as of March 1, 2024.

_____ _____

Patient or Authorized Representative Signature | Printed Name

_____ _____

Today's Date | Relationship to Patient (if applicable)

Assignment of Benefits and Financial Responsibility

Patient Name: _____

Date of Birth: _____

ASSIGNMENT OF BENEFITS: The undersigned hereby assigns all health insurance benefits and/or Medicare/Medicaid benefits and/or Foundation payments to Urology Cancer Center d/b/a XCancer. A photocopy of this assignment shall be as valid as the original.

FINANCIAL RESPONSIBILITY: The undersigned understands that he/she is financially responsible to Urology Cancer Center d/b/a XCancer as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges not covered by the above assignments may include medical insurance deductibles, co-insurance and out-of-pocket expenses. The undersigned understands that he/she may be asked to sign additional acknowledgements of this financial responsibility.

The undersigned represents that if Patient's insurance policy requires prior authorization, or if Patient is a member of a managed care organization that requires Patient to use a preferred provider, all such conditions have been met. The undersigned certifies that he or she has read the foregoing, or had the foregoing read to him or her, and is the Patient or Legal Guardian or Power of Attorney duly authorized by and on behalf of the Patient to execute this document and accept its terms.

Patient's Signature/Power of Attorney/Legal Guardian:	Date:
Responsibility Party's Signature (If not the same as above)	Date:
Witness to Signature:	Date:

Luke Nordquist, M.D., F.A.C.P.
Urology Cancer Specialist

17607 Gold Plaza
Omaha, NE 68130

ph: 402.991.8468
fax: 402.991.8469
cell: 402.659.2819
email: drnordquist@gucancer.com

HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s): Relationship:

_____ _____

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information:

(check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify_____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____

Name of the Individual Giving this Authorization

_____ _____

Signature of the Individual Giving this Authorization Date

TELEMEDICINE CONSENT

Telemedicine allows for a routine visit with your Oncologist or Nurse Practitioner (NP) without leaving your home. Telemedicine has gained nationwide acceptance by patients, Medicare, Medicaid, insurance companies and healthcare professionals since the COVID 19 Pandemic. Telemedicine may be performed over the phone or in some instances requires video conferencing with the use of your phone or computer.

Not all patients will always be a candidate for a telemedicine visit. If for example, you are acutely ill, on treatment, or have imaging scans to review that may require an in-person visit. Telemedicine visits are ideal for patients who are not sick, have no new issues, and/or if you have to travel a distance to our clinic. One of our healthcare team members will notify you ahead of time if you are a candidate for a telemedicine visit. You will always have the option to refuse a telemedicine visit if you prefer to see us in person.

Patient Statement

I understand that if I participate in a telemedicine visit that I will communicate with either a Physician or Nurse Practitioner at the Urology Cancer Center by telephone or video only and that it will be billed to my insurance as a telemedicine claim and I may be responsible for the standard copay.

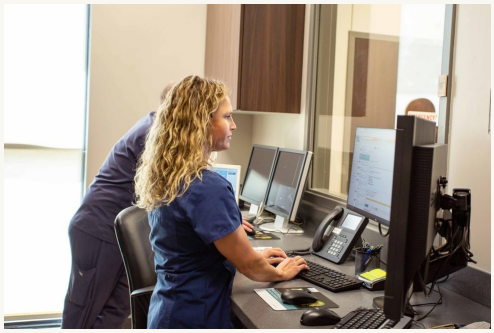
_____	_____	_____
PRINT NAME	*SIGNATURE*	*DATE*

RESOURCES

IN THE MEANTIME CHECK OUT THE UROLOGY CANCER CENTER'S OTHER ENTITIES. WE ARE MORE THAN JUST CANCER CARE. WE STRIVE EVERY DAY TO MAKE A DIFFERENCE WORLDWIDE.

01 **XCANCER RESEARCH**

www.xcancerresearch.com



03 **XCANCER STORE**

www.xcancerstore.com

02 **XCANCER FOUNDATION**

www.xcancer.com/xcancer-foundation

04 **XCANCER TRIALS**

www.xcancertrials.com

REVIEWS

SEE WHAT OTHERS HAVE TO SAY!

★★★★★

healthgrades™

WWW.HEALTHGRADES.COM

vitals™

WWW.VITALS.COM

THANK YOU!

Thank you for completing our welcome packet. This information will help us prepare for your visit and make check-in a breeze. Please bring this packet with you along with your photo ID, primary, secondary, and prescription insurance cards to your appointment on:

_____ at _____ with a check-in time at _____

If you have any questions, please don't hesitate to call us at (402) 991-8468 and we will be happy to assist you.

X CANCER®

Protocol for Referrals to UCC

When a new patient visit is scheduled please collect the following information :

- **Patient's first name, middle name, and last name** : _____
- **Patient's date of birth** :_____
- **Social security number** :_____
- **Phone number** : _____
- **Email Address** : _____
- **Address** : _____
  (Street) (City) (State) (Zip)

Insurance (Required)

- **Primary Insurance Name :** _____
- **Member ID :** _____
- **Effective Date :** _____
- **Secondary Insurance Name** : _____
- **Member ID** : _____
- **Effective Date** : _____

  ☐ Check Box if Patient has no Insurance and is Self Pay

- Referring Physician Name : _____
- Self Referral – **How did you hear about us?**
  - ☐ Research Study –if yes, name of study _____
  - ☐ Healthcare Professional – if yes, name of HCP _____
  - ☐ Family _____
  - ☐ UCC Patient _____
  - ☐ Neighbor/Friend _____
  - ☐ Advertisement/Media _____
  - ☐ Internet _____

- **Urologist :** _____ **(if same as referring please write same)**
- **Primary Care :**_____ **(if same as referring please write same)**

- **Other Physicians (Please list name *and specialty*) :**

  _____

  _____

- **Date referral was called to UCC** : _____

- **<u>Urgency for appointment</u>**
  - ☐ Urgent (1-3 business days)
  - ☐ Standard (4-14 business days)
  - ☐ Alternative (15 or more business days)

- **Location of Outside Labs : _____ (if none, write none)**
- **Location of Outside Radiology : _____(if none, write none)**
- **Location of any other outside tests (location and type; date of diagnosis) :**

  _____

  _____

- **Cancer Diagnosis :** _____

Day and time for patient appointment given to referring physician, PCP, or patient :_____

- ☐ Notified referring physician or PCP to fax pertinent medical records.
- ☐ Notified referring physician or PCP that the UCC physician and midlevel will communicate all relevant urologic cancer results to the patient and family/caregiver(s) during the duration of their urologic cancer care.

Front Desk Initials (person responsible for scheduling appointment) : _____

REFERRAL CONFIRMATION LETTER

Luke Nordquist, M.D., F.A.C.P.
Urology Cancer Specialist
17607 Gold Plaza
Omaha, NE 68130
Ph: 402.991.8468
Fax: 402.991.8469
Cell: 402.659.2819
Email: drnordquist@gucancer.com

To: _____
(Referring Physician or PCP)

_____
(Organization Name)

_____
(Fax Number)

Date of Referral Phone call to UCC : _____

You recently referred an individual, _____
(First Name Last Name DOB)
to the Urology Cancer Center to see Dr. Luke Nordquist. The patient will be seeing Dr. Nordquist on _____
at _____ for their _____. This notification is to confirm receipt of the referral for your records. If there are any changes to the patient's appointment our office will contact your office via phone and also fax an updated referral confirmation letter. If you have any questions regarding the patient's appointment or feel that something on this form is incorrect please contact our office at 402-991-8468 and any one of our patient advocates can assist you. As soon as the patient's appointment is completed Dr. Nordquist will fax a completed office visit note with his findings, recommendations, and plan of care to your physician.

Sent by: _____ Date Faxed: _____
(UCC Staff Member First and Last Name)

REFERRAL CONFIRMATION LETTER

Luke Nordquist, M.D., F.A.C.P.
Urology Cancer Specialist
17607 Gold Plaza
Omaha, NE 68130
Ph: 402.991.8468
Fax: 402.991.8469
Cell: 402.659.2819
Email: drnordquist@gucancer.com

To: _____
(Referring Physician or PCP)

_____
(Organization Name)

_____
(Fax Number)

Date of Referral Phone call to UCC : _____

_____referred an individual, _____
(First Name Last Name DOB)
to the Urology Cancer Center to see Dr. Luke Nordquist. The patient will be seeing Dr. Nordquist on _____
at _____ for their _____. This notification is to confirm receipt of the referral for your records. If there are any changes to the patient's appointment our office will contact your office via phone and also fax an updated referral confirmation letter. If you have any questions regarding the patient's appointment or feel that something on this form is incorrect please contact our office at 402-991-8468 and any one of our patient advocates can assist you. As soon as the patient's appointment is completed Dr. Nordquist will fax a completed office visit note with his findings, recommendations, and plan of care to your physician.

Sent by: _____ Date Faxed: _____
(UCC Staff Member First and Last Name)