PATIENT INITIAL HISTORY QUESTIONNAIRE

+Name:		Date of Birth:	Age:
Street:	Please provide us with the names of your physicians		
City, State, Zip:	Family Physician		
Preferred Nickname:	Referring Physician		
Day Phone:	Medical Oncologist		
Work Phone:	Other Physician		
Cell Phone:	Other Physician		
Can we leave a message on your voice mail? ❒ Yes ❒ No	Can we call you at work? ❒ Yes ❒ No		

Please provide at least one emergency contact:

Emergency Contact	Phone Number	Relationship
Second Emergency Contact (if available)	Phone Number	Relationship

Before you were referred did you know there was a cancer center in Soldotna? Yes No

Before referral did you hear or see us anywhere else? Circle all that apply: Facebook Our Website Google Advertisements Radio Ads Other (please specify): _____

OTHER MEDICAL SERVICES

Please check if you have seen any of the following specialists:

❒ Radiation Oncologist ❒ Medical Oncologist ❒ Surgeon ❒ None Apply

PAST CANCER HISTORY

Have you ever had any of the following?

❒ Prior Cancers ❒ Prior Radiation ❒ Prior Chemotherapy ❒ None Apply

Are you taking hormonal therapy? (i.e., Tamoxifen) ❒ No ❒ Yes If yes, what?

_____

Where was your cancer treatment?

_____

Patient Name: _____

MEDICAL HISTORY *Please include all current or past medical conditions* ❒ None

Past Medical History	Year of Diagnosis

SURGICAL HISTORY *List any surgeries and year performed.* ❒ None

Past Surgery	Year

MEDICATIONS *List all current medications and doses and any herbs, supplements or vitamins* ❒ None

Medication/Supplement	How Many Do You Take Daily?	Reason for Taking Medication/Supplement

ALLERGIES *List all allergies and reactions.* ❒ None

Allergy	Reaction

Patient Name: _____

FAMILY HISTORY of CANCER

Immediate		Type of Cancer	Maternal		Type of Cancer	Paternal		Type of Cancer
Mother	❒ Yes		Grandmother	❒ Yes		Grandmother	❒ Yes	
Father	❒ Yes		Grandfather	❒ Yes		Grandfather	❒ Yes	
Sister	❒ Yes		Aunt	❒ Yes		Aunt	❒ Yes	
Brother	❒ Yes		Uncle	❒ Yes		Uncle	❒ Yes	
Children	❒ Yes							

WORK HISTORY

Occupation (current or before retirement) _____

Are you still working? ❒ Yes ❒ No

Were you exposed to carcinogenic substances, asbestos? ❒ Yes ❒ No List:

PAIN

Do you have pain? ❒ Yes ❒ No

If yes, Where? _____

Please rate your current pain on a scale of 1-10. 1 being best, or no pain. 10 being worst, or intolerable.

0	1	2	3	4	5	6	7	8	9	10

What is this pain from if applicable? _____

HISTORY OF TOBACCO, ALCOHOL and DRUGS

Tobacco

❒ No ❒ Yes Ever use tobacco? How many packs per day? _____

❒ No ❒ Yes Currently use tobacco? What age started? _____

What age stopped? _____

If yes, check type(s):

❒ Cigarettes ❒ Snuff
❒ Pipe ❒ Chew
❒ Cigars ❒ Other _____

Alcohol

❒ No ❒ Yes Do you drink alcohol? If yes, how many drinks per day? _____

Drugs

❒ No ❒ Yes Currently use illegal drugs (or marijuana)? If yes, what drugs? _____

Patient Name: _____

ADVANCE DIRECTIVE (Living Will)

We are required by the State to inquire.

Do you have an Advance Directive?	❒ Yes ❒ No
Do you have a Do Not Resuscitate / Do Not Intubate Directive?	❒ Yes ❒ No
If yes, would you provide us with a copy for your medical record?	❒ Yes ❒ No
If you do not have an advance directive, would you like information?	❒ Yes ❒ No

Information for advance directive provided by: _____ *Date:*_____

REVIEW OF SYSTEMS: Please √ any of the items that apply to you or that you may be experiencing.

GENERAL
Normal Weight: _____
❒ Recent Weight Loss
Amount: _____
❒ Recent Weight Gain
Amount: _____
❒ Loss of appetite
❒ Fatigue
❒ Fevers or chills

EYES
❒ Cataracts
❒ Double vision
❒ Changes in vision
❒ Other vision problems_____

EARS/NOSE/THROAT
❒ Loss of hearing
❒ Nose bleeds
❒ Dental problems
❒ Hoarseness
❒ Difficulty swallowing
❒ Neck pain or swelling
❒ Other symptoms _____

CARDIOVASCULAR
❒ Pacemaker
❒ Chest pain
❒ Irregular heartbeat
❒ Palpitations
❒ Fainting spells
❒ Leg pain while walking
❒ Other _____

RESPIRATORY
❒ Shortness of breath
❒ Coughing
❒ Coughing up blood
❒ Oxygen use at home, Liters?___
❒ Other_____

GASTROINTESTINAL
❒ Heartburn
❒ Nausea
❒ Abdominal pain
❒ Blood in stool
❒ Other_____

GENITOURINARY
❒ Difficulty urinating
❒ Blood in urine
❒ Other_____

WOMEN ONLY
❒ Menopause (Age) _____
_____ # of pregnancies
_____ age of first pregnancy
_____ # of live births
❒ Hormone therapy
❒ Pain in breast
❒ Lump or mass in breast or armpit
❒ Change in nipple

MUSCULOSKELETAL
❒ Leg cramps
❒ Muscle weakness
❒ Physical disabilities
❒ Other_____

SKIN
❒ Rash
❒ Sores
❒ Growths

NEUROLOGICAL
❒ Headaches
❒ Tremors
❒ Numbness or tingling
❒ Dizziness
❒ Loss of consciousness
❒ Seizures
❒ Unsteady gait
❒ Other_____

PSYCHIATRIC
❒ Anxiety
❒ Depression
❒ Other_____

ENDOCRINE
❒ Excessive thirst
❒ Thyroid problems
❒ Other_____

HEMATOLOGIC & LYMPHATIC
❒ Swollen lymph glands
❒ Excessive bruising or bleeding
❒ Other_____

I verify the above information is true and correct to the best of my belief.

Patient Signature _____ Date:_____

Reviewed by_____ Date:_____

Patient Name:
Date of Birth:

Patient Financial Responsibility Agreement

At Peninsula Radiation Oncology Center, we truly appreciate the opportunity to provide you with compassionate, state-of-the-art care. This Agreement identifies your financial obligations for all the services you receive from us, including the services provided today and in the future. Please let us know if you do not understand any of the items discussed in this agreement.

- Please inform us of ALL insurance coverage you possess, and of any recent changes. This is crucial for proper billing and to ensure insurance coverage for our services, when available. We need correct and current information on a timely basis. If your insurance coverage changes, please contact our office immediately at 541-304-2264.
- If you do not have insurance, payment of 50% of the estimated treatment costs will be required before treatment starts. The front office coordinator will provide an estimate and payment option for you.
- You are responsible for obtaining any necessary referrals from your primary care physician and prior approval before the start of treatment if required by your insurance company. Please speak to the front office coordinator or contact our business office at 866-353-0360 if you need assistance.
- You are personally responsible to us for the full payment of all services you receive from us. All co-payments and/or deductibles for our services are due at the time of service. At your request, a financial counselor can provide you with an estimate of your financial responsibility for your treatment. However, please understand that an estimate is not binding and that the actual cost may be different. We accept payment for daily co-pays via cash, check, or credit card.
- We will submit a claim to your primary and secondary insurance for all services that we provide to you. If we do not receive payment within 30 days of submission or your insurance notifies us that you are not covered under your insurance plan (e.g. the services were not pre-authorized), you will pay us the outstanding balance of the services. We will send you a statement for the amount due. If your account, including reasonable attorneys' fees and collection costs. If we eventually receive a payment from your primary or secondary insurance, we will refund the difference to you.
- You authorize and direct any insurance proceeds payable for services provided by us to you to be paid directly to us, and assign to us, without recourse, all interest in and rights to claim, collect and receive the proceeds from any insurance company providing

coverage for our services. You authorize any insurance company to furnish to use and our agents all information pertaining to your insurance benefits and the status of any and all claims submitted by us.

- We are Medicare providers and accept assignment from Medicare. However, there may be a balance due from you after Medicare pays. Medicare law prohibits us from waiving this balance.

I have read this Agreement, understand its content, and agree to its provisions.

Sign here: _____

Date: _____

Authorization for Release of Medical Records

PENINSULA Radiation Oncology CENTER

*Please fill in highlighted areas only

Section A: This section must be completed for all Authorizations			
Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:		
	City:	**State:**	**Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Medication Sheets		☐ Operative Information ☐ Special test/therapy ☐ Nursing Information ☐ Transfer forms ☐ Clinical Test		☐ Itemized bill: ☐ Other: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?	☐ Yes ☐ No
If yes, describe:	

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Notification of Disclosure to Persons Involved in Your Case & Emergency Contacts

Patient Name		Date of Birth	Age
Street	City	State/Zip	

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about your radiation treatments, medications, prescriptions, billing, schedule appointments or otherwise discuss any aspect of your care or treatment with anyone other than you.

If you would like us to be able to discuss information related to your care with specific persons, please list those persons below.

Name & Phone Number	Relationship to Patient

Patient Comments: _____

_____

I hereby authorize Peninsula Radiation Oncology Center to discuss all aspects of my treatments with the above listed persons.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record for all health professionals who may provide treatment or who may be consulted by our staff members.

Payment. Your health information may be used to see payment from your health insurance plan, from other sources of coverage, or from credit card companies that you may use for payment of services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Southeast Radiation Oncology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Public Health Reporting. Your information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred prior to your notification of your decision to us.

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and or submit corrections to our protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Peninsula Radiation Oncology Center's Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy privileges and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policy and practices may be required in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office coordinator.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to the contact person listed below.

If you believe that your privacy rights have been violated, you should call the matter to the attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filing a complaint.

Contact Person
The name and address of the person that you may contact for further information concerning our privacy practice is:

Privacy Officer
Peninsula Radiation Oncology Center
240 Hospital Place
Soldotna, AK 99669

Your signature is an acknowledgement of receipt that you have read the Notice of Privacy Practices. If you request a copy of your notice, it will be provided.

Sign Here:_____

Date:_____

PHOTO AND MULTIMEDIA RELEASE FORM

I understand and agree to allow my name, photograph, story, and video/audio to be used in any number of marketing purposes and communication vehicles for the promotion or Peninsula Radiation Oncology Center (PROC), and RBS Evolution (RBSE).

This may include, but is not limited to, business website or other features, social media, biographies, brochures, magazine articles, national and regional advertising on TV, online. radio, newspaper, trade magazines, outdoor properties, and specialized microsites.

- I hereby authorize PROC/RBSE and those acting on its behalf to:
    - Record my image, likeness, and/or voice in a photographic, video, audio, digital, electronic or any other medium.
    - Use, reproduce, modify, exhibit, and/or distribute any such recording in any medium for any purpose that RBS may deem appropriate, including promotional or advertising effort with no compensation to me.
    - Use my name in connection with any such recordings.

I understand that I shall have no right to inspect or approve any such recordings and photos and that they shall remain the property of PROC/RBSE. I release PROC/RBSE and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with all such recordings and uses. I have read and fully understand the terms of this release.

Printed Name: _____

Signature: _____

Date Signed: _____