KATMAI ONCOLOGY GROUP
www.katmaioncology.com

Anchorage Office
3851 Piper Street, Suite U340
Anchorage, AK 99508
(907) 562-0321
(907) 562-2683 fax

Soldotna Office
247 N. Fireweed Street, Suite B
Soldotna, AK 99669
(907) 262-1310
(907) 262-1309 fax

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Name: _____ **Date of Birth:** _____
First M Last

Social Security #: _____-_____-_____ **Gender:** M ☐ F ☐ **Marital Status:** S ☐ M ☐ W ☐ D ☐

Race: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Language:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph #: _____ **Cell #:** _____ **E-mail:** _____

Employer: _____ **Work Phone:** _____

Preferred Contact Method: Home ☐ Cell ☐ Work ☐ **Message OK:** Home ☐ Cell ☐ Work ☐

Referring Physician: _____ **Primary Care Physician:** _____

Preferred Pharmacy: _____ **Location:** _____

SPOUSE

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Address:** _____

City/State: _____ **Zip:** _____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

EMERGENCY

Name/Relationship	Phone	Allowed to talk with about:
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD TO COPY)

PRIMARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

SECONDARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Acknowledgement of Release of Medical Records and Payment Policy

Release of Medical Information

- I authorize Katmai Oncology Group to release and/or obtain any medical records concerning myself from/to any physician, hospital, or agency involved with my care.
- I authorize Katmai Oncology Group to download my prescription reimbursement history electronically.

Assignment of Medical Benefits

- I authorize my insurance carrier to assign all medical benefits, if applicable, to Katmai Oncology Group.
- I authorize release of medical information necessary to process all medical insurance claims.

Usual and Customary Rates

- We, Katmai Oncology Group, charge what is usual and customary for our area.
- I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Policy

- Co-payments are to be collected at the time services are received. We accept cash, check, Visa, and MasterCard.
- All medical services provided are directly charged to the patient or responsible party.
- If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed.
- I will be responsible for any balance deemed patient responsibility/non-payable/non-covered by my insurance and billed accordingly.
- Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.
- If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me.
- This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

_____ _____

(Patient's Signature – or legal representative) *(Date of signature)*

_____ _____

(Print Patient's Name) *(Legal representative's relationship to patient)*

KATMAI
ONCOLOGY GROUP

Patient Medical and History Information Sheet

Name: _____ **Date of Birth:** _____ **Date:** _____

SYMPTOMS (check symptoms you currently have, or have had in the *recent* past)

Weight change in the past year: ☐ increase ☐ decrease By how much: _____

- ☐ Fever
- ☐ Night sweats
- ☐ Vision trouble
- ☐ Dizzy spells
- ☐ Severe headaches
- ☐ Hearing trouble
- ☐ Depression
- ☐ Cough
- ☐ Shortness of breath
  (If so, with what activity:_____)
- ☐ Blood in sputum
- ☐ Fast, irregular or slow pulse
- ☐ Chest pain or discomfort
- ☐ Swollen lymph nodes
- ☐ Trouble swallowing
- ☐ Trouble with appetite
- ☐ Trouble sleeping
- ☐ Abdominal pain or swelling
- ☐ Blood in vomit or stool
- ☐ Change in bowel habits
- ☐ Black bowel movements
- ☐ Diarrhea
- ☐ Frequent indigestion
- ☐ Nausea, vomiting
- ☐ Constipation
- ☐ Burning when passing urine
- ☐ Blood in urine
- ☐ Swelling in the legs
- ☐ Numbness/tingling
  (If so, where: _____)
- ☐ Joint or bone pain
  (If so, where: _____)
- ☐ Breast pain, lump, discharge
- ☐ Skin rashes
- ☐ Easy bruising or bleeding

Other symptoms of concern: _____

CONDITIONS (check conditions you have, or have had in the past)

- ☐ History of cancer
- ☐ Kidney disease
- ☐ Heart disease
- ☐ Stroke, seizure, or other neurological disorder
- ☐ Blood clot
- ☐ High blood pressure
- ☐ Goiter or thyroid trouble
- ☐ Lung disease
- ☐ Liver disease
- ☐ Mental health disorder
- ☐ Diabetes or sugar in urine
- ☐ Blood transfusion(s)

Surgeries/Injury/Hospitalization	When

PLEASE COMPLETE BOTH SIDES OF THIS FORM

ALLERGIES (i.e., medications, food(s), latex, dye, adhesive tape, bee stings, etc.) ☐ **None**

Allergy/Sensitivity	Reaction

FAMILY HISTORY (is there a history of cancer, blood disorders or other medical problems in your family?)

Family Member	Living Status	Age, now or at death	Medical Problem(s)	Cause of Death	If cancer, age at diagnosis
Father	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Mother	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Other family members with cancer?			**Who:**	**Type:**	

PREVENTATIVE HEALTH MAINTENANCE

Female: Last mammogram:_____
Last colonoscopy:_____
Last pap smear: _____
Last bone density:_____

Male: Last prostate exam:_____
Last PSA screening:_____
Last colonoscopy:_____

SOCIAL HISTORY

Current occupation:_____ Previous occupation(s):_____

Marital status: ☐ Married ☐ Single ☐ Widow(ed) ☐ Divorced

Live with: ☐ Family ☐ Alone ☐ Other:_____

Tobacco use: ☐ Never ☐ Current ☐ Past Start date:_____ Quit date:_____

Type (circle): Cigarettes / cigars / pipe / chew / e-cigarette Packs per day/Amount:_____

Alcohol use: ☐ Yes ☐ No Drinks per week: _____

For Women:

Number of pregnancies:_____ Age at first pregnancy:_____ Number of children:_____

Age at first period:_____ Last menstrual period:_____ Age at menopause:_____

Vaginal symptoms: ☐ Abnormal bleeding Start date: _____
☐ Other Describe: _____

Edmonton Symptom Assessment Scale (ESAS) New Patients

Patient Name: _____ Date of Birth: _____

Katmai Physician: _____ Today's Date: _____

Over the last 7 days please circle the number that best describes

0	1	2	3	4	5	6	7	8	9	10
No pain										Worst possible pain
0	1	2	3	4	5	6	7	8	9	10
Not tired										Worst possible tiredness
0	1	2	3	4	5	6	7	8	9	10
Not nauseated										Worst possible nausea
0	1	2	3	4	5	6	7	8	9	10
Not depressed										Worst possible depression
0	1	2	3	4	5	6	7	8	9	10
Not anxious										Worst possible anxiety
0	1	2	3	4	5	6	7	8	9	10
Sleeping well										Not sleeping
0	1	2	3	4	5	6	7	8	9	10
Great appetite										No appetite
0	1	2	3	4	5	6	7	8	9	10
Participating in things I enjoy										Not participating at all
0	1	2	3	4	5	6	7	8	9	10
No shortness of Breath										Worst possible shortness of breath
0	1	2	3	4	5	6	7	8	9	10
I take care of myself										I need full assistance

I have concerns today regarding:

- ☐ **Health Insurance**
- ☐ **Filling your prescriptions**
- ☐ **Transportation to medical appointments**
- ☐ **Housing during treatment**
- ☐ **Work**
- ☐ **Finances**

Katmai offers integrative support services with the following providers.

I am interested in an appointment with:

- ☐ **Counselor**
- ☐ **Registered Dietitian**
- ☐ **Massage Therapist**
- ☐ **Acupuncturist**

Your insurance will be billed for these services

MEDICATION LIST

Name:_____

Please list all the medications you are taking, including herbs and supplements

MEDICATION	DOSE	FREQUENCY	START DATE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

KATMAI ONCOLOGY GROUP

Advance Directive Acknowledgement

An Advance Directive is a legal document which tells your doctor what kind of care you want and who you have appointed to make health care decisions if you are no longer able to make decisions for yourself.

If you have an Advance Directive please provide a copy for your medical record.

If you do not have an Advance Directive, our Social Worker can provide you with information to help you develop an Advance Directive regarding your healthcare.

☐ I **do not** have an Advance Directive. I **would** like more information.

☐ I **do not** have an Advance Directive. I **do not** want information at this time.

☐ Yes, I do have an Advance Directive.

- ☐ Please find attached.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient's Signature Date

KATMAI ONCOLOGY GROUP

Patient Portal: My Care Plus
User Authorization Form

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

You may use your own personal e-mail address, or assign an Authorized Designee's e-mail address to access the Portal. If you assign an Authorized Designee, they (and you) must understand that by signing this form, the listed e-mail address will be utilized for Portal purposes.

If you choose to sign-up for the Portal, you receive an e-mail with unique link that you will use to create a password in order to access your personal health record. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. Please contact your physician's office if you require a new link sent to your e-mail address.

Because personal information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you change email addresses, or if you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please print clearly.

☐ **I DO want to sign-up for the Patient Portal (please complete & sign below)**

OR

☐ **I do *NOT* want to sign-up for the Patient Portal**

_____
Printed Patient Name

_____
Date of Birth of Patient

_____
Email Address of Patient/Authorized Designee

_____
Patient's Signature

_____
Authorized Designee's Name

_____
Authorized Designee's Signature
(if available or applicable)

_____
Date

Staff Use Only *(initial when complete)*:

"Primary" E-mail in iKM_____	Patient Portal in iKM_____
Treatment Location in iKM_____	Invite sent via Portal_____

KATMAI ONCOLOGY GROUP

Consent for Unsecure E-mail / Text

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has standards for protecting the privacy and confidentiality of individuals health information. Katmai Oncology Group follows these laws and regulations by offering encrypted (secured) e-mail communication through the My Care Plus Patient Portal.

If you want to communicate with Katmai by unencrypted (unsecured) e-mail or text, your written consent is required. Unsecured communication sent through the internet or over the phone systems means that unauthorized persons may be able to access the information sent.

By answering "YES" you allow Katmai to communicate with you through unsecured methods, you are agreeing that Katmai and its staff are NOT liable for any losses, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unsecured e-mails, texts, and / or attachments. This consent will remain effect until revoked in writing. It may be revoked in writing at any time.

Please indicate your choice below:

☐ **YES, I allow Katmai to send unsecured e-mail or text** *(please print clearly)*

- ☐ E-mail (use this e-mail address):_____
- ☐ Text (use this phone number): (____) ____-____

OR

☐ **NO, I do NOT allow Katmai to send unsecure e-mail or text**

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient's Signature Date

KATMAI
ONCOLOGY GROUP

Acknowledgement of Notice of Privacy Policy

By signing this form, I acknowledge that I received a copy of Katmai Oncology Group's Notice of Privacy Policy. I understand that I may request another copy of the policy at any time.

_____ _____

(Patient's Signature – or legal representative) *(Date of signature)*

_____ _____

(Print Patient's Name) *(Legal representative's relationship to patient)*

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Notice of Privacy - Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights *(see below section for more detailed information)*

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices ***(see below section for more detailed information)***

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures *(see below section for more detailed information)*

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Respond to lawsuits and legal actions
- Address workers' compensation, law enforcement, and other government requests

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- You can ask to communicate with your provider in a private / quiet area in the clinic.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. An electronic copy will always be available at the above website.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Please provide copies of any legal documentation.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us - we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We are legally allowed to and will typically use or share your health information without your consent in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

- *Example: We use health information about you to manage your treatment and services.*

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Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

- *Example: We may provide your health or demographic information to your health plan to pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- With health oversight agencies for activities authorized by law
- For law enforcement purposes or with a law enforcement official
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. You will not be required to sign another acknowledgement of receipt form.

This notice becomes effective on January 17, 2017.