



2841 DEBARR ROAD | SUITE 100 | ANCHORAGE, AK 99508 | (907) 276 - 2400

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Local Phone \_\_\_\_\_ May we leave a message on your recorder?  Yes  No Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_

Do you have a hospital preference? \_\_\_\_\_ Pharmacy? \_\_\_\_\_

Parent/Legal Guardian (if not patient) \_\_\_\_\_

Marital Status  Married  Single  Widowed  Divorced Sex  Male  Female

If married, Spouse's Name \_\_\_\_\_ May we contact?  Yes  No

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Insurance \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy # \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

**PATIENT PAYMENT AGREEMENT**

I understand that I am responsible for my medical bill and accept responsibility for any charges not covered and paid by my insurance company or other third party resources.

- If my insurance company requires pre-certification/authorization for services, I understand that it is my responsibility to obtain that authorization prior to the scheduled appointment.
- By signing below, I authorize the release of my medical records to the insurance carrier as may be necessary to determine benefits and to process claims for health care services provided to the above named patient.
- I authorize assignment of Medicare/Medicaid, other federal/state agents or any commercial insurance carriers to pay benefits directly to the provider of service(s).
- This is a Lifetime insurance authorization granting the provider authority to file claims on my behalf.

In addition to the above patient payment agreement, I sign below acknowledging receipt of the office's NOTICE OF PRIVACY PRACTICES

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**

1) WHAT IS YOUR MAIN REASON FOR COMING HERE? \_\_\_\_\_

Where and when was this diagnosed? \_\_\_\_\_

Please select anything that you may need help with below:

Housing in Anchorage  Yes  No      Finances  Yes  No      Care at Home  Yes  No  
 Medical Equipment  Yes  No      Transportation  Yes  No      Emotional Support  Yes  No

Other (Please Explain) \_\_\_\_\_

2) LIST ALL PREVIOUS DOCTORS/PHYSICIANS YOU HAVE SEEN, INCLUDING FIRST NAME, CITY, STATE AND PHONE

Doctor/Physician	City/State	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) ALLERGIES TO FOOD OR DRUGS

Food or Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

4) MEDICINES USED REGULARLY

Medication Name	Dosage	Used For:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) PLEASE LIST ANY PREVIOUS CANCER TREATMENTS, INCLUDING RADIATION THERAPY

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6) LIST ALL OTHER PREVIOUS SURGERIES (INCLUDE DATE, REASON AND DOCTOR)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7) PLEASE LIST ANY PROBLEM(S) YOU MAY HAVE HAD

- Heart attack                       Arthritis                                       Difficulty urinating                                       Circulation problems
- Seizures/Epilepsy                       Ulcer     Kidney problems                                       Hepatitis/Jaundice at birth
- Gall bladder disease                       Change in bowel habits                                       Mental health problems                                       Tuberculosis
- Liver disease                                       Cancer     Other lung disease                                       Pneumonia
- Stroke     Diabetes     Chronic bronchitis/Emphysema                                       High blood pressure
- Transfusion                                       Other \_\_\_\_\_

8) FOR WOMEN – MENSTRUAL HISTORY

Age period began \_\_\_\_\_ Cycle \_\_\_\_\_ days Is your cycle regular at this time?  Yes  No  
 Any abnormal discharge or bleeding?  Yes  No Birth Control or other hormones?  Yes  No  
 Age at menopause \_\_\_\_\_ How many children? \_\_\_\_\_ How many pregnancies? \_\_\_\_\_  
 Age at first term delivery \_\_\_\_\_ Still Births \_\_\_\_\_ Abortions \_\_\_\_\_ Did you breast-feed?  Yes  No

9) SOCIAL HISTORY

Birthplace \_\_\_\_\_ Do you live alone?  Yes  No  
 Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_  
 Do you have children?  Yes  No Ages of Children \_\_\_\_\_  
 Occupation \_\_\_\_\_ Unemployed?  Yes  No Retired?  Yes  No  
 Have you had any of the following in the last 2 years?  
 Change of Job?  Yes  No Previous occupation \_\_\_\_\_  
 Change of residence?  Yes  No Environmental exposures?  Yes  No  
 Loss of spouse, relative or friend?  Yes  No Do you have interests or hobbies that you pursue with any regularity?  Yes  No  
 If yes, what? \_\_\_\_\_  
 \_\_\_\_\_  
 Have you traveled outside the country?  Yes  No If yes, approximate dates \_\_\_\_\_

10) HAVE YOU EVER USED TOBACCO?  Yes  No

Type:  Cigar  Cigarette  Pipe  Snuff  Chewing Tobacco How much? \_\_\_\_\_ How often? \_\_\_\_\_  
 Have you quit?  Yes  No If yes, when did you quit? \_\_\_\_\_

11) HAVE YOU EVER USED ALCOHOL?  Yes  No

Are you currently using alcohol?  Yes  No What kind (beer, wine, hard liquor)? \_\_\_\_\_  
 How much? \_\_\_\_\_ How Often \_\_\_\_\_

12) DO YOU USE RECREATIONAL DRUGS OF ANY KIND?  Yes  No

What Kind? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_



15) PLEASE COMPLETE YOUR FAMILY HISTORY IN THE CHART BELOW

FAMILY MEMBER	ALIVE?	AGE/AGE AT DEATH	LIST ANY HEALTH PROBLEMS
Paternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Paternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		

FOR NURSE'S USE

B/P \_\_\_\_\_ PULSE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ BSA \_\_\_\_\_

Revised 11/2011





Date \_\_\_\_\_

2841 DEBARR ROAD | SUITE 100 | ANCHORAGE, AK 99508 | P: 907.276.2400 | TOLL-FREE: 877.276.4655 | F: 907.276.4888  
2490 S. WOODWORTH LP. | SUITE 150 | PALMER, AK 99645 | P: 907.745.2900 | TOLL-FREE: 877.276.4655 | F: 907.745.2999

## PRIVACY POLICY

### NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

**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.**

If you have any questions about this notice, please contact the Privacy Officer by dialing (907) 276-2400.

### INTRODUCTION

At the Anchorage Radiation Therapy Center, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

### Understanding Your Health Record/Information

Each time you visit a hospital, physician, or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care or treatment, and billing-related information.

### Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

### Uses and Disclosures

How we may use and disclose Medical information about you. The following categories describe examples of the way we use and disclose medical information:

**For Treatment:** We may use medical information about you to provide you treatment or services. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you.

We may also provide other physicians or subsequent healthcare providers, participating in your medical care, with copies of various reports that should assist him or her in their decisions to manage and coordinate your medical needs.

**For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payments from you, your insurance company, or a third party payer. For example, we need to give your insurance company information about your treatment so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Options:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine medical information we have with that of other hospitals to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

We may also use and disclose medical information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To inform funeral directors consistent with applicable law;
- For population based activities relating to improving health and reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include utilizing a billing service to submit claims, and engineers hired to maintain equipment that holds personal health information through electronic media. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Individuals Involved In Your Care or Payment For Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research:** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

**Future Communications:** We may communicate to you via newsletters, mail outs, or other means regarding treatment options, health related information, disease-management programs, wellness programs, follow-up appointments, or other community based initiatives or activities our facility is participating in.

**Organized Health Care Arrangement:** This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

**As required by law,** we may also use and disclose health information for the following types of entities including but not limited to:

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**State-Specific Requirements:** Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the State privacy laws are more stringent than Federal privacy laws, the State law preempts the Federal law.



Date \_\_\_\_\_

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**Your Health Information Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

- **Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care as provided for in 45 CFR 164.524. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information as provided in 45 CFR 164.528. You have the right to request an amendment for as long as the information is kept by or for the hospital. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Account of Disclosures:** You have the right to request an accounting of disclosures as provided in 45 CFR 164.528. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations.
- **Request Restrictions:** You have the right to request a restriction or limitation on medical information we use or disclose about you for treatment, payment or health care operations as provided by 45 CFR 164.522. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. Mail. The center will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for service rendered by the facility and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the center and include the effective date.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the center by contacting the main number and asking for the Privacy Officer or with the Secretary of the Department of the Health and Human Services. The address for the Office for Civil Rights is listed below:

**Office for Civil Rights**  
US Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Bldg.  
Washington D.C. 20201

All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice, or the laws that apply to us, will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided to you.

**PRIVACY OFFICER: Kari Disbrow**  
(907) 276-2400

**SIGNATURE:** I have fully read and understand this Privacy Policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date