



2490 S. WOODWORTH LP. | SUITE 150 | PALMER, AK 99645 | (907) 745-2900

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



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PATIENT AUTHORIZATION

Patient Name _____ Date _____

I, _____ authorize the Valley Radiation Therapy Center Staff to send and/or discuss my past, current, and future medical records to/with the following physicians and hospitals:

PHYSICIAN/HOSPITAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ authorize the following individual(s) to discuss and/or request my medical issues/records on my behalf:

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

BILLING RECORDS

I, _____ authorize the following named individuals to discuss my billing related information with the office and billing service staff.

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ understand that I have the right to revoke authorizations assigned above at any point in time with the understanding that any records released or information communicated prior to this revocation were duly authorized.

 Patient Signature Date



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