1 PATIENT INFORMATION

Today's Date:_____

☐Mr. ☐Mrs. ☐Ms. **Last Name:**_____ **First Name:**_____**Middle Initial:** _____

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

Primary Phone:_____Is it OK to leave a message about your care? ☐Yes ☐ No Brief or Extended

Secondary Phone:_____Is it OK to leave a message about your care? ☐Yes ☐ No Brief or Extended

Work Phone:_____ Is it OK to leave a message about your care? ☐Yes ☐ No Brief or Extended

Please circle one

Doctor that sent you here: _____ **Your regular/primary care Doctor:**_____

Other Doctors you are seeing:_____

Date of Birth (MM/DD/YYYY):_____**Age:** _____ **Sex:** ☐M ☐F **Social Security:**_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated **Student:** Full-time_____ Part-time_____

Occupation:_____ **Employer:**_____

Employer's Address:_____**City:**_____**State:**_____**Zip Code:** _____

Emergency Contact:_____**Phone:**_____**Relation:** _____

Patient Email:_____**Language:** ☐English ☐Other: _____

Race: ☐Indian/AK Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐African American ☐Caucasian ☐Hispanic ☐Other Decline

Ethnicity: ☐Hispanic/Latin American ☐Not Hispanic/Latin American ☐Decline

Preferred Pharmacy:_____**City:**_____**State:** _____

2 PERSON RESPONSIBLE FOR THE BILL ☐ Same as above.

Full Name:_____ **Primary Phone:**_____**Secondary Phone:** _____

Address:_____**City:**_____**State:**_____**Zip Code:**_____

Date of Birth (M/D/Y):_____ **Sex:** ☐Male ☐Female

3 INSURANCE INFORMATION

Primary Insurance:_____

Policy #:_____**Group #:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

Secondary Insurance:_____

Policy #:_____**Group #:** _____

Mailing Address:_____

City:_____**State:**_____ **Zip:** _____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

Workers Comp/Motor Vehicle Accident: Date of Injury:_____ **Claim #:**_____

ALASKA SURGICAL ONCOLOGY

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

Office Visit Date: _____ **Age**:_____

Reason for visit: _____

_____

History of Present Illness or Injury: Is this illness/injury employment related? Yes or No

Please answer all questions. If one does not apply to you, please write N/A (not applicable)

- Location of discomfort/pain: _____
- What makes symptoms better or worse:_____
- (Pain scale 1-10, 1 being minimal and 10 being severe) Pain Severity:_____
- When did the pain begin?_____ How long have you had symptoms/pain?_____
  How long does it last? _____
- Timing (When do the symptoms occur….. after meals or exercise, etc.)? _____

  _____
- Symptoms (Character of symptoms/pain….. burning, gnawing, stabbing, etc)? _____

  _____

  _____

Current Medications

Name of Medication	Dosage	How often taken

ALASKA SURGICAL ONCOLOGY

Printed Name:_____

Past Medical History (Personal): Please circle ***Yes*** if you have any of the following medical problems and please answer the questions regarding the problem. Circle ***No*** if you do not have the problem.

High Blood Pressure
Yes No

Diabetes
Yes No

On Insulin
Yes No
Type: _____

Heart Trouble
Yes No
Explain: _____

Stroke/TIA (mini stroke)
Yes No

Bleeding Problems
Yes No
Explain:_____

Angina/Chest Pain
Yes No
How often:_____
On extension: Yes No
At rest: Yes No

Hepatitis
Yes No
A___B___C___

Respiratory Problems
Yes No____COPD____Asthma
Explain:_____

Heart Attack
Yes No
Date of Attack: _____

Blood Clots/DVT
Yes No

HIV/AIDS
Yes No

Cancer
Yes / No / I don't know Year Diagnosed: _____
Site of Cancer:_____

Chemo Therapy
Yes No

Radiation Therapy
Yes No Printed

Previous Tests
Previous studies:

____CT Scan Date:_____ Location:_____
____MRI Date:_____ Location:_____
____X-Ray Date:_____ Location:_____
____Mammogram Date:_____ Location:_____
____Colonoscopy Date:_____ Location: _____

Allergy Information Please list any type of allergy and associated reactions (i.e. medication, food, latex, etc)

Allergy	Reaction

ALASKA SURGICAL ONCOLOGY

Printed Name:_____

List all Surgeries

Type of Surgery	Date of Surgery	Dr. who performed surgery

Family Medical History:

Please check all that apply.

	Cancer - Type/Location	Diabetes	Heart Disease	Stroke	Bleeding Disorder	Other
Father						
Mother						
Sister						
Brother						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						

Social History

Tobacco Use: ____Never _____Former User, Quit Date _____

____Current User, Amount per day _____ Years Used _____

____Cigarettes ____Cigars ____Smokeless

Drug Use

____Never If drug use: Current: Yes/No Former User: Yes/No Years Used:_____

Type:_____

Alcohol Use: Yes____No____ Typical # of servings per week:_____

ALASKA SURGICAL ONCOLOGY

Review of Symptoms

General

____None
____Fever/Chills/Sweats
____Fatigue
____Weight Gain
____Weight Loss
____Pain Location:_____
____Level (0-10)
Other_____

Gastrointestinal Nutrition

____None
____Nausea or Vomiting
____Problems Swallowing
____Reflux or Indigestion
____Blood in stools
____Black/Tarry Stools
____Diarrhea
____Constipation
____Yellow skin or eyes
Other_____

Pregnancy Are you currently pregnant? Yes or No

Integumentary / (Breast – Skin)

____None
____Breast Mass or Lump
____Bloody Nipple Discharge: Left / Right
____Breast Pain: Left / Right
____Change in Mole: Location_____
____Rash: Location _____
____Open Sore: Location_____
Other_____

Cardiovascular

____None
____Chest Pain
____Palpitations
____Swelling Hands/Feet
Other_____

Hematologic/Lymphatic

____None
____Easy Bruising
____Abnormal Bleeding
____Swelling in groin/armpit/neck
Other_____

Psychiatric

____No issues
____Depression
____Anxiety
Other_____

Musculoskeletal

____None
____Joint pain/Swelling
____None Back pain
Other _____

Neurologic

____None
____Frequent Headaches
____Paralysis or Tremors
____Convulsions/Seizures
____Numbness/Tingling
Other_____

Respiratory

____None
____Shortness of breath
____Cough
____Wheezing/Asthma
____Bloody Sputum
Other _____

Genitourinary

____None
____Blood in Urine
____Stool in Urine
____Kidney Stones
____Unable to control bladder
Other _____

Patient Statement:

To the best of my knowledge, the above information is correct and complete.

Printed Name:_____ Signature:_____

Date:_____

ALASKA SURGICAL ONCOLOGY

FINANCIAL POLICY

We understand that many patients find financial matters surrounding their medical care to be very complex and often times confusing. If you have any questions regarding our billing policies, we will be happy to assist you.

Private Health Insurance	Initial Here _____	We are a contracted, "preferred", or considered In-Network with ***some*** private health insurance plans. As the patient, you are responsible for requesting prior approval and/or Out-of-Network benefit level exceptions from your insurance company as required. Our office collects a standard 20% of amount due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicare	Initial Here _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient-notified non-covered services after Medicare processes your claim. No payment is required at the time of service.
Medicaid	Initial Here _____	We are a contracted provider with Medicaid. You must present a current sticker/card for each month of eligibility. Please note, a referral is required if you are in the Lock-in Program; without a referral you will be considered a self-pay patient. Your co-pay is due at the time of service and failure to make payment may result in delayed future appointments.
Tricare / Triwest / VA	Initial Here _____	We are a non-network provider with Tricare and Triwest. We will bill Tricare and Triwest on your behalf as a courtesy. You will be responsible for any account balance not covered by your plan. VA visits must be preauthorized by your referring physician.
Workers Compensation	Initial Here _____	We only accept Workers' Compensation claims that were filed with the Alaska or Washington Departments of Labor. Your claim must be open and accepted. You must complete a Physician Report as well as provide your carrier's information including claim number and date of injury. No payment is required at the time of service.
Self-Pay / Uninsured	Initial Here _____	Payment is due in full at the time of service unless other billing arrangements have been approved by the Billing Department.
Auto Accident	Initial Here _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved by the Billing Department.
Payment Plan	Initial Here _____	Payment plans must be established through the Alaska Surgical Oncology Billing Department. Please note our payment plans are determined on an individual basis. All payments will be applied to the oldest date of service first.
Other	Initial Here _____	

- I have read, understand, and agree to this financial policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Alaska Surgical Oncology to release medical information to my insurance carrier to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Alaska Surgical Oncology
- I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- I will be held responsible for all fees associated with the collection of my account balance.

Name of Patient:_____ Signature of Patient:_____

ALASKA SURGICAL ONCOLOGY

MEDICATION POLICY

NARCOTICS/CONTROLLED SUBSTANCES

The providers of Alaska Surgical Oncology do not routinely prescribe narcotics on a long-term basis. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management provider. When indicated, long-acting opiates are prescribed in extremely limited quantities without automatic refills. Narcotic prescriptions will not be refilled after office hours or on weekends. By signing this policy, you agree to stay consistent with the use of the one pharmacy as listed below. If you have a current pain control contract with any healthcare provider, please provide the name of the provider and bring this to our attention at the time of your first appointment. We will assist you in arranging for postoperative pain control through that provider.

NAME OF PAIN CONTRACT PROVIDER:_____ ____N/A

PHARMACY: _____

Report lost or stolen medications to the police immediately and provide a copy of the police report to our office. We will consider a replacement prescription on a case-by-case basis and only with a copy of a valid police report. It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore you agree that, unless otherwise authorized, the physicians at Alaska Surgical Oncology will be the sole narcotic prescription source for you at this time. Furthermore, by accepting controlled substances from Alaska Surgical Oncology, you agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office.

Per Alaska law, prescription(s) for controlled substances are entered in the state drug monitoring database and may be accessed for limited purposes by specified individuals.

In the postoperative period, we may continue to aid you in pain control with the goal that you will taper and eventually discontinue your pain medications. If this cannot happen in a timely manner, you will be referred to a provider who can aid in this process.

REGARDING PRESCRIPTION REFILLS

Alaska Surgical Oncology has a 48 hour medication turn-around. Prescription requests submitted after 3 pm may not be called in until 2 business days later. Please allow ample time for this process. We do not refill prescriptions over the weekend. Be sure to submit your request before noon on Friday if you need your prescription filled on Monday. This is not guaranteed. For your own convenience, call your pharmacy before leaving home to make sure they have your prescription ready. Alaska Surgical Oncology providers will not refill prescriptions for patients not seen in the past 90 days by a Alaska Surgical Oncology provider.

ACKNOWLEDGEMENT OF PRESCRIPTION POLICY

I have read and understand Alaska Surgical Oncology's policy regarding prescription medications. I agree to the terms involved in the Medication Policy.

_____	_____	_____
Patient name (Printed)	Signature of patient/Patient Representative	Date

YOUR PERSONAL AND HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed):_____ Signature:_____ Date: _____

ALASKA SURGICAL ONCOLOGY

Protected Health Information Authorization

I,_____, date of birth_____, Authorize Alaska Surgical Oncology to speak to the person(s) listed regarding any and all of my medical and personal information:

- _____ Relationship to Patient _____
- _____ Relationship to Patient _____
- _____ Relationship to Patient _____

I,_____Authorize Alaska Surgical Oncology to release and dispense my medications to:

- _____ Relationship to Patient _____
- _____ Relationship to Patient _____
- _____ Relationship to Patient _____

I understand and assume responsibility of notifying Alaska Surgical Oncology whenever the listed information changes. I understand this excludes insurance companies, attorneys and other health care providers.

Signed:_____

Date:_____

Witness/Staff Signature:_____

Date:_____

3851 Piper Street Tower U, Suite U230
Anchorage, Alaska 99508

Phone (907)868-2075

Fax (907) 312-5882

ALASKA
SURGICAL ONCOLOGY

Physician ownership disclosure form

During the course of your treatment with Alaska Surgical Oncology (Dr. Charles Portera), you may be referred to the following Ambulatory Surgery Center. Federal law requires physicians to notify a patient if the physician has an ownership or investment interest in any entity to which the physician is referring the patient.

We are hereby disclosing to you that Dr. Portera has an investment interest in:

Muldoon Ambulatory Surgery Center
6911 Debarr Rd.
Anchorage, AK 99504

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider and the option of obtaining health care ordered by your physician at a different facility other than Muldoon Ambulatory Surgery Center. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers. If you have any questions concerning this notice, please feel free to contact our office manager.

Your signature below documents your informed decision to decline the option to have your health care provided at another health care facility.

Date: _____

Signature of Patient or Patient: _____

Printed Name of Patient: _____

Date of birth:____/___/___