ALASKA SURGICAL ONCOLOGY

Personal Information

___Mr. ___Mrs. ___Ms.

Last Name: _____ **First Name**:_____

Date of Birth (M/DD/YYYY): _____ **Age**: _____ **Sex**: M / F **Marital Status**: _____

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

Email: _____ **Social Security #:** _____ **Language**: _____

Race:_____ **Ethnicity**: Hispanic / Latin American ***OR*** Non - Hispanic / Latin American

Dr. who sent you to this office:	Primary Care Doctor:	Other Doctors you are seeing:

Care and Appointment reminders:

I, _____ Authorize Alaska Surgical Oncology to leave Appointment Reminders by the following methods.

Home: _____ Voicemail: Yes or No Brief or Extended

Cell: _____ Voicemail: Yes or No Brief or Extended

Work: _____ Voicemail: Yes or No Brief or Extended

Occupation: _____

Employed: Yes/No Retired: Yes/No Other_____

Employer: _____

Employer Address:_____ City: _____ State: _____ Zip:_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Person Responsible for the bill: Same as above ____

Full Name: _____ Cell: _____ Work: _____

Address:_____ City: _____ State: _____ Zip:_____

Date of Birth: _____ Sex: M / F

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Insurance Information:

Policy Holder: _____ DOB: _____ Policy Holder: _____ DOB: _____

Primary Insurance: _____ Secondary Insurance: _____

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

Mailing Address: _____ Mailing Address: _____

City: _____ State:__ Zip:_____ City: _____ State:__ Zip:_____

Medication:

Preferred Pharmacy	City	State

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

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

Personal Health Information:

I, _____ 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 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:_____

ALASKA
SURGICAL ONCOLOGY

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 _____	VA and Tricare visits must be preauthorized by your referring physician. We will bill Tricare on your behalf, however, you are responsible for your deductible/Co-pay and Co-insurance amounts as determined by Tricare.
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 Kenai Spine 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 Kenai Spine 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 bases. 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:_____

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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 in place please provide the name of the provider with whom you have the contract 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: _____

We ask that you report either lost or stolen medications to the police immediately and that you provide a copy of the police report for our records. We will not replace lost or stolen pain medications without a copy of a valid police report. Having a copy of a valid police report does not guarantee that we will replace your prescription and each situation will be assessed on a case-by-case basis. 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 Prescribing 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.

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

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I,_____, authorize Alaska Surgical Oncology to view my external prescription history via the Rx Hub service. I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewed by my providers and staff here. My signature certifies that I have read and understand the scope of my consent and authorize the access.

_____ _____

Signature of patient/Patient Representative Date

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Printed Name:_____

Date of Birth: _____ **Age**:_____

Office Visit Date: _____

Reason for visit: _____

_____

History of Present Illness or Injury: Is this illness/injury employment related? Yes 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)? _____

  _____

  _____

Printed Name: _____

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Current Medications

Name of Medication	Dosage	How often taken

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

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Printed Name: _____

Allergy Information

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

Allergy	Reaction

List all Surgeries

Type of Surgery	Date of Surgery	Dr. who performed surgery

Family Medical History:

Please circle Yes, No, or Unknown as appropriate for parents, grandparents, siblings, and children.
If yes, please list relation to patient:

Cancer – Type/Location	Yes No Unknown	
Diabetes	Yes No Unknown	
Heart Disease	Yes No Unknown	
Stroke	Yes No Unknown	
Bleeding Disorder	Yes No Unknown	

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Printed Name:_____

Social History

Tobacco Use: ____Never

____Current User ____Former User

Cigaretts/cigars/dip/snuff/chew: Years used_____ Packs/Cigars per day _____

Pouch/Can per day _____

Drug Use

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

Type:_____

Alcohol Use: Yes____ No____

Review of Symptoms

General

____None

____Fever/Chills/Sweats

____Fatigue

____Weight Gain

____Weight Loss

____Pain Location:_____

____Level (0-10)

Other_____

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_____

Gastrointestinal Nutrition

____None

____Nausea or Vomiting

____Problems Swallowing

____ Reflux or Indigestion

____ Blood in stools

____ Black/Tarry Stools

____ Diarrhea

____Constipation

____Yellow skin or eyes

Other_____

Cardiovascular

____None

____Chest Pain

____Palpitations

____Swelling Hands/Feet

Other_____

Printed Name:_____

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Hematologic/Lymphatic

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

Psychiatric

____No issues
____Depression
____Anxiety
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 _____

Musculoskeletal

____None
____Joint pain/Swelling
____Back pain
Other _____

Pregnancy

Are you currently pregnant? Yes or No

Previous Tests

Previous imaging studies or other studies:

____CT Scan Date:_____ Location:_____
____MRI Date:_____ Location:_____
____X-Ray Date:_____ Location:_____
____EMG Date:_____ Location:_____

Patient Statement:

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

Printed Name:_____

Signed:_____

Date:_____

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 for 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: ___/___/___