

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 also 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. You are 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. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your 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 Signature: _____ **Date:** _____

Katmai Oncology Group
3851 Piper Street, Suite U340
Anchorage, AK 99508
Phone 907-562-0321 Fax 907-562-2683

Date: _____

Name: _____

Birth Date: _____

Has your weight increased ____ (Y/N) or decreased ____ (Y/N) in the past year?

By how much: _____

Do you have symptoms now or have you had significant problems in the past with:

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

Other symptoms of concern: _____

Do you have or have you had the following condition(s), and for how long:

Goiter or thyroid trouble	Yes	No	How long_____	Kidney stones or other			
Lung trouble	Yes	No	How long_____	kidney disease	Yes	No	How long_____
Heart trouble	Yes	No	How long_____	Ulcer of stomach or intestine	Yes	No	When_____
Hepatitis or other				Stroke, seizure, or other			
liver disease	Yes	No	How long_____	neurological disorder	Yes	No	When_____
Blood clot	Yes	No	When_____	Diabetes or sugar in urine	Yes	No	How long_____
High blood pressure	Yes	No	How long_____	Blood transfusion(s)	Yes	No	When_____

ALLERGIES:

What allergies do you have? (medicine, latex, dye, tape, other)

What was the reaction?

FAMILY HEALTH HISTORY:

	Age, now or at death	Major Illnesses	Cause of death if deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
	_____	_____	_____
Sister	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Other cancers in the family? Who: _____ Type: _____

Have you had screening for early cancer detection:

Colon cancer Last time: _____ Breast cancer Last time: _____
 Cervical cancer Last time: _____ Prostate cancer Last time: _____

About Yourself:

Current occupation: _____ Previous occupation(s): _____

Check one: _____ Married _____ Single _____ Widow(ed) _____ Divorced

Live with: _____ Family _____ Alone _____ Other

Do you use tobacco products? _____ yes _____ no Amount _____ How long _____

Did you use tobacco products in the past? _____ yes _____ no Amount _____ How long _____

Do you drink alcohol? _____ yes _____ no Amount: _____

Surgical & Medical History:

Serious illness(es): Type? _____ When? _____

Serious injuries: _____

Surgeries: _____

For Women:

Number of pregnancies: _____ Age at first pregnancy? _____ Miscarriages: _____ Living Children: _____

Age when menstrual periods began: _____ ended: _____

Any abnormal vaginal bleeding? _____ Yes _____ No

Other vaginal symptoms? If yes, describe: _____

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 LLC
3851 Piper Street, Suite U340 | Anchorage, Alaska 99508
907-562-0321

By signing this form, I acknowledge that I have received a copy of Katmai Oncology Group LLC's Privacy Practice Notice.

Patient Signature(or legal representative)

Date

Legal Representative's relationship to patient

A good faith effort was made to obtain the patient's acknowledgment of the receipt of the notice of Privacy Practices. The following identifies the efforts made and the reason the acknowledgment was not obtained.

Signature of Katmai Oncology Group LLC
Staff member

Date