Midnight Sun Oncology

- Registration Form -

Patient Information

(Please Print)

Date: _____ Home / Message Phone: _____

Cell / Other Phone: _____

Name: _____ SSN: _____
(Last) (First) (MI)

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ DOB: _____ Marital Status: _____

Employed By: _____ Work Phone: _____

Spouse's Name: _____

Spouse's SSN: _____ Spouse's DOB: _____

Emergency Contact/ Relationship: _____/_____

Home Phone: _____ Cell / Work / Other Phone: _____

Referred By: _____ Reason: _____

Assignment and Release

I authorize my insurance benefits to be paid directly to the Doctor. I understand that I am financially responsible for any balance due, including any collection or processing fees. I hereby authorize the Doctor to release all information necessary to secure payment of benefit and the use of this signature below on all insurance submissions.

Patient Signature: _____ Date: _____

Midnight Sun Oncology

- Health History -

(Confidential)

Name: _____

Reason for Visit: _____

Symptoms - Please *circle* any symptoms you currently have or have had in the past:

General
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headaches
Loss of Sleep
Nervousness
Loss of Weight
Numbness
Sweats

Muscle/Joint/Bone
(pain, weakness, numbness)
Arms Hips
Back Legs
Feet Neck
Hands Shoulders

Genito-Urinany
Blood in Urine
Frequent Urination
No Bladder Control
Swelling of Ankles
Painful Urination

Gastrointestinal
Appetite Poor
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal Bleeding
Stomach Pain
Vomiting
Vomiting Blood

Cardiovascular
Chest Pain
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Poor Circulation
Rapid Heart Beat

Eye/Ear/Nose/Throat
Bleeding Gums
Blurred Vision
Crossed Eyes
Difficulty Swallowing
Double Vision
Earache
Ear Discharge
Hay Fever
Hoarseness
Loss of Hearing
Nosebleeds
Persistent Cough
Ringing in Ears
Sinus Problems
Vision Flashes/Halos

Skin
Bruise Easily
Hives
Itching
Change in Moles
Rash
Scars
Sore(s) that won't heal
Varicose Veins

Men Only
Breast Lump
Erectile Dysfunction
Lump in Testicles
Penis Discharge
Sore on Penis
Other: _____

Women Only
Abnormal Pap Smear
Bleeding between Periods
Breast Lump
Extreme Menstrual Pain
Vaginal Discharge
Hot Flashes
Nipple Discharge
Painful Intercourse
Other: _____
Day of Last Period _____
Day of Last PAP _____
Day of Last Mammogram
_____
Number of Children
_____

Conditions - Please *circle* any conditions you have or have had in the past:

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate Problem
Psychiatric Care
Scarlet Fever
Stroke
Suicide Attempts
Thyroid Problems
Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers
Vaginal Infections
Venereal Disease

Family History - On the left please input health information about your family. On the right please check if any blood relatives have had any of the following and their relationship to you.

Relation	Age	Age at death	Cause of death	✔	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sister					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations/Serious Illness & Injuries

Year	Hospital/Illness/Injury	Reason

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No** **If Yes, please list dates** _____

Pregnancy History

Number of Pregnancies	Number of Live Births	Complications (if any)

Health Habits - Please check which substances you use and describe how often you use them.

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Occupational Concerns - Write your occupation and then check if your work exposed you to the following.

Occupation:		
	Stress	
	Hazardous Substances	
	Heavy Lifting	
	Other	

Medications - List any that you are currently taking.

Allergies - List allergies to any medications or substances.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctors or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Office Policies for Midnight Sun Oncology

Refills

1. All prescription refill(s) requests require two (2) business days. There will be absolutely NO EXCEPTIONS. Please take weekends and holidays into consideration when calling in for refills.
2. Requests will all be done and ready for fax/pick-up at the end of the second day.

Appointments

1. Patients are seen by appointment only.
2. If you show up 15 minutes or more late for an appointment, you WILL be rescheduled to the next available time slot.
3. If you "No Show" and appointment three (3) times it will be grounds for termination of your doctor-patient relationship.

Confirmation Calls

1. All calls will be done no later than the first business day BEFORE the day of your appointment. If you are not available we will leave a message letting you know what time your appointment is.
2. We ask that you please give 24 hours notice if you are unable to make your scheduled appointment time.

Medical Records

1. If you are requesting a copy of your medical records we ask for at least 48 hours notice. We will do our best to accommodate you and get this done as soon as we can, but we cannot make any guarantees.
2. You will need to sign a release for our office to either send or receive your medical records from another physician.
3. Absolutely NO results will be given out over the phone. If you want to discuss them with your physician, you will need to make an appointment.

Miscellaneous

1. All insurance copays and deductibles are due at the time of service.
2. All self-pay fees are due at time of visit.
3. Please turn off all cell phones during appointments.

Midnight Sun Oncology Partners, LLC

2490 S. Woodworth Loop Suite 499
Palmer, AK 99645
Phone: (907) 746-7771
Fax: (907) 746-7798

Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003, and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

Typical uses and disclosures of health information

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letter

Your privacy rights as our patient

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Please contact the front desk for a copy of this form. You may also request access by sending us a letter to the address at the beginning of this Notice. Please allow 24-48 hours for the staff to have an opportunity to get the information for you. If there is an emergent need, we will do our best to make arrangements to accommodate you.

Amendment: If you feel your healthcare information is inaccurate or incomplete you have the right to amend it. Under certain circumstances, your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use, or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.) Please contact the front desk if you want to further restrict access to your health care information. This request must be submitted in writing.

Acknowledgement of receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Printed Name

_____

Signature

_____

Date

Midnight Sun Oncology Partners, LLC
2490 S. Woodworth Loop Suite 499
Palmer, AK 99645
Phone: (907) 746-7771
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Patient Acknowledgement and Consent Form

The Department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. In order to provide services that are in your best interest, when it is appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information, information about treatment, and payment or health care operations.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships between our office and other companies pertaining to your care (i.e. laboratories that only interact with physicians). It is possible that we may have to disclose personal health information for the purpose of treatment, payment or health care operations. These entities are not required to obtain patient consent.

I understand that my health records may include information both created and received by this practice. This information may be in the form of writing, electronic records, and spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health related symptoms. I understand and agree that this practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plans or insurance coverage and submit bills, claims, and other related information to insurance companies or a responsible agent for payment of my health care.
- Perform various offices, administrative, and business functions that support my physician's effort to provide me with, arrange, and be reimbursed for quality health care.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing as mandated by the Privacy Act. Under this law, we have the right to refuse treatment should you choose not to disclose your information. I also understand that I have the right to ask that some or all of my health care information not be used or disclosed, and understand that this practice is not required by law to agree with such requests.

I have reviewed and understand this consent form.

_____ _____

Patient Signature Date