

**Midnight Sun Oncology**  
**- Registration Form -**

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**Patient Information**  
(Please Print)

Date: \_\_\_\_\_

Home / Message Phone: \_\_\_\_\_

Cell / Other Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (MI)

SSN: \_\_\_\_\_

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-Urinary

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	4	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.

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Printed Name

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Signature

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Date

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**2490 S. Woodworth Loop Suite 499**

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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