SUMMIT
CANCER CENTERS

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential.

Name: _____ Male Female

Maiden name: _____ (Circle one) Single Married Divorced Widowed Domestic Partnership

DOB: _____ Social Security Number: _____ Email address: _____

Mailing address: _____ City/State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Place of birth: _____

Employer: _____ Occupation: _____

Referring physicians name: _____ Primary care physicians name: _____

Preferred language: _____ Ethnicity: Hispanic Not Hispanic/Latino Decline

Race (please circle): American Indian or Alaskan Native Black or African American Asian
Native Hawaiian or Other Pacific Islander Caucasian Hispanic or Latino

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Please list individuals we are authorized to speak to regarding your care/account.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

NEAREST FRIEND/RELATIVE TO CONTACT IN CASE OF AN EMERGENCY

Name: _____ Phone: _____ Relationship: _____

(Continued on reverse)

Person responsible for payment: (if patient is a minor under 18) _____

Mailing address: _____City/State: _____Zip: _____

Phone: _____ Relationship to patient: _____

Employer of responsible party: _____

PRIMARY MEDICAL INSURANCE: _____

Policy Number: _____ Group Number: _____

Subscriber name: _____ DOB: _____ Employer: _____

SECONDARY MEDICAL INSURANCE: _____

Policy number: _____ Group Number: _____

Subscriber name: _____ DOB: _____ Employer: _____

I have completed the above information to the best of my knowledge. I request that payment of authorization benefits be made to me or on my behalf to Summit Cancer Centers for any services furnished me. I authorize Summit Cancer Centers to release any medical information which may be requested to determine benefits through my above named insurance carrier, prepaid medical plan, government agency or the Health Care Financing Administration. I understand that if any insurance does not pay in full for services provided by Summit Cancer Centers, I assume liability for the unpaid portion. This agreement shall be governed and enforced in accordance with the laws of the State of Washington. Jurisdiction and proper venue for enforcement shall lie in Spokane County, State of Washington.

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT/SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made to me, on behalf to Summit Cancer Centers for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine these benefits, or the benefits payable for related services.

PATIENT SIGNATURE: _____ DATE: _____

SUMMIT CANCER CENTERS

Patient Name: _____ Date of Birth: _____ Date: _____

Health History

ANY previous surgical procedures or operations: ☐ YES ☐ NO

Date	Type	Facility

IMPLANTED DEVICES: Do you have any implanted or metal devices? ☐YES ☐NO

☐ Venous Access Device/Type_____ ☐Pacemaker ☐Aneurysm Clip ☐Stent

☐ Screws, pins, plates (Where? _____) ☐Other_____

Claustrophobia: ☐ **YES** ☐ **NO**

PREFERRED PHARMACY: _____

DRUG ALLERGIES: ☐ **YES** ☐ **NO** If yes, please list **ALL ALLERGIES** and **TYPE OF REACTION**:

_____

_____

CURRENT MEDICATIONS: (Please list all medication that you are currently taking (including non-prescription medications and/or herbal, vitamin and nutritional supplements).

Medication	Strength	Frequency	Prescriber	Purpose of Medication

MEDICAL HISTORY: Do you have any other previous or ongoing medical conditions? If yes, briefly describe conditions and treatments below.

High blood pressure: ☐ YES ☐ NO _____

Heart disease: ☐ YES ☐ NO _____

Diabetes: ☐ YES ☐ NO Requires Insulin? ☐ YES ☐ NO

Thyroid dysfunction: ☐ YES ☐ NO ___Overactive? ___ Underactive?

Testicular pain/Swelling: ☐ YES ☐ NO _____

Hernias: ☐ YES ☐ NO _____

Auto-immune Disease: ☐ YES ☐ NO _____

Any cancer history: ☐ YES ☐ NO _____

Other chronic illness: ☐ YES ☐ NO _____

Any previous radiation: ☐ YES ☐ NO If yes, where were you treated? _____

MEN ONLY:

Do you have regular PSA tests? ☐ YES ☐ NO Date of last exam: _____

WOMEN ONLY- Obstetrics /Gynecology History

Are you pregnant? ☐ YES ☐ NO Is there a chance you could be pregnant? ☐ YES ☐ NO

Age at 1st Menstrual Period: _____ Date of last menstrual period: _____

Age at menopause (if applicable): _____

Hysterectomy: ☐ YES ☐ NO Were the ovaries removed: ☐ YES ☐ NO

Type of birth control currently used: _____

Do/did you use oral contraceptives? ☐ YES ☐ NO If yes, for how long? _____

Do/did you use hormone replacement? ☐ YES ☐ NO if yes, for how long? _____

Number of pregnancies: _____ Number of live births: _____ Age at first full term pregnancy: _____

Date of last mammogram: _____ Date of last PAP/Pelvic Exam: _____

SOCIAL HISTORY:

Married? ☐YES ☐NO Your Occupation: _____

Do you live: ☐Alone ☐ With spouse/significant other ☐ With family ☐ Other _____

Do you have children? ☐YES ☐NO If so, how many? _____

Do you have a religious and/or cultural belief we should be aware of during your treatment? ☐ YES ☐ NO

If yes, please describe: _____

Patient Name (Please Print) _____

HEALTH MAINTENANCE:

Do you have any dental problems? ☐YES ☐ NO Dentures: ☐YES ☐ NO

Have you had a colonoscopy/sigmoidoscopy? ☐ YES ☐ NO If so, date of last one: _____

Have you had flu vaccination? ☐ YES ☐ NO If so, date of last vaccination: _____

Have you had pneumonia vaccination? ☐ YES ☐ NO If so, date of last vaccination: _____

Consent to give immunization history to Public Health? ☐ YES ☐ NO

Please indicate if you use any of the following in your regular routine:

☐ Crutches ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other: _____

FAMILY HISTORY:

Father: ☐ Alive (age) _____ ☐ Deceased (at what age)_____ Cause of death:_____

Mother: ☐ Alive (age) _____ ☐ Deceased (at what age)_____ Cause of death:_____

Total Number of Sisters: _____ Number of Deceased Sisters: _____ Cause of death: _____

Total Number of Brothers: _____ Number of Deceased Brothers: _____ Cause of death: _____

Do/did any family members suffer from any form of cancer or blood disease?

Family Member	Type of cancer/blood disease	Age at time of diagnosis	Alive/Deceased (circle one)	If Deceased, cause of death and age
			A D	
			A D	
			A D	

SUBSTANCE HISTORY: Have you ever smoked? ☐ YES ☐ NO *(If yes, please answer the following questions.)*

Do you currently smoke? ☐ YES ☐ NO Do you currently use chewing tobacco? ☐ YES ☐ NO

How many packs per day? _____ How many years? _____ If you no longer smoke, date you quit: _____

Do you use recreational drugs? ☐ YES ☐ NO If yes, which drugs? _____

Have you ever consumed alcohol? ☐ YES ☐ NO *(If yes, please answer the following questions.)*

Do you currently consume alcohol? ☐ YES ☐ NO If yes, number of drinks per week: _____

Please circle all that apply: Beer Wine Spirits

If you previously drank alcohol, when did you stop? _____

Patient Name (Please Print) _____

REVIEW OF SYSTEMS: *(Check all that apply.)*

☐ Recent weight change	☐ Chest pain	☐ Rectal bleeding	☐ Headaches
☐ Loss of appetite	☐ Heart palpitations	☐ Bowel incontinence	☐ Seizures
☐ Fever	☐ Light headedness	☐ Burning on urination	☐ Dizziness
☐ Shaking / Chills	☐ Swelling in legs	☐ Pain with urination	☐ Loss of balance
☐ Night sweats	☐ Passing out	☐ Blood in urine	☐ Weakness of limbs
☐ Fatigue	☐ Cough	☐ Frequent urination	☐ Loss of sensation
☐ Blurred vision	☐ Sputum production	☐ Urinary incontinence	☐ Numbness
☐ Double vision	☐ Blood in sputum	☐ Muscle pain	☐ Tingling sensation
☐ Hearing loss	☐ Shortness of breath	☐ Stiffness	☐ Memory loss
☐ Ringing in ears	☐ Nausea	☐ Joint pain / Arthritis	☐ Difficulty thinking
☐ Sinus trouble	☐ Heartburn	☐ Back pain	☐ Lumps in arm pits
☐ Trouble swallowing	☐ Vomiting	☐ Skin rash	☐ Lumps in neck
☐ Sore throat	☐ Constipation	☐ Skin problems	☐ Breast lumps
☐ Nose bleeds	☐ Diarrhea		☐ Nervousness
☐ Hoarseness	☐ Abdominal pain		☐ Depression

Patient Signature: _____ Date: _____

Patient Name (Please Print) _____

Reviewed by RN: _____ Date: _____

SUMMIT
CANCER CENTERS

Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal and privacy practices with respect to health information about you
- Follow the terms of the Notice of Privacy Practices that is currently in effect

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- Food and Drug Administration reporting of adverse product defects or recalls
- Legal authorities and safety purposes, organ and tissue donations
- As required by law, law enforcement, lawsuits and disputes
- Coroners, health examiners and funeral directors
- National security, Military and Veterans Administration
- Correctional Institutions
- Worker's Compensation

Your rights regarding health information about you:

- Right to inspect and copy; amend or correct
- Right to an accounting of disclosures
- Right to request restrictions on release of information
- Right to request confidential communications
- Right to a paper copy of this notice (full notice is available upon request)

Change to Notice of Privacy Practices:
We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact our HIPAA Privacy Officer to file a complaint.

Acknowledgment of receipt of this notice:
We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records.

Patient signature Date

Print name

SUMMIT
CANCER CENTERS

PATIENT FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. Our Physicians are committed to providing quality care to our patients, while helping to control the rising costs of medical care. This is an agreement between Summit Cancer Centers and the Patient/Guarantor named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

For

Physician Professional Fees

Insurance Account: If you have insurance, we will bill your insurance. Any outstanding balance is due in 30 days after insurance pays. If your insurance doesn't pay us, the full amount is due no later than 90 days after the date of service unless prior arrangements have been made with our business office.

Patients with **State Medical Assistance** must present a current card at the time of service. In the event of Medicaid Spend Down, please be advised that you are responsible for the charges incurred until spend down has been met.

No insurance

If you have no insurance, a down payment of $150.00 is required at the time of service unless other arrangements have been made prior to your visits.

- Cash Account: We offer a 15% discount for payment in full on the day of service
- Bankcards: A 10% discount is offered if paid in full on the day of service

Account responsibility

Many people are under the impression that if they have insurance, it is the insurance company that owes Summit Cancer Centers for their services. This is **not** the case. The insurance contract is **between you and the insurance company**; our relationship to you is as a patient of one of our physicians or mid-level practitioners. Your insurance company requires us to collect applicable co-pays at the time of service. Estimates of coinsurance and deductibles are also due to the time of service.

If the Physician recommends radiation therapy, an appointment will be made with Summit Cancer Centers Financial Counselors to discuss the estimated treatment cost and patient responsibility. Payment arrangements and possible assistance from outside sources are available on a case by case basis.

Payment options

You may pay by cash, debit, Visa, MasterCard, American Express and personal check.

(continued on reverse)

Arrangements with outside financing are made with our Financial Counselor if you qualify.

Balances older than 60 days may be subject to additional collections fees and interest charges of 1% per month.

Returned checks: A $25.00 processing fee is charged for all returned checks. After one returned check, we no longer will accept checks from you.

Our responsibility

- To bill all claims to your insurance carrier(s) in a timely manner on your behalf.
- To assist you in resolving any problems with claim payment.

Your responsibility

- To provide us with current and accurate information to submit your claims correctly.
- To make certain there is authorization for treatment if it is required by your insurance.
- To pay your co-payment at the time of service or a $10.00 service will be added. **WE CAN NOT BILL YOU FOR CO-PAYS.**
- To pay any additional amount owed as directed by your insurance carrier within 60 days of receipt of your first statement from us.

Usual and customary charges

Some insurance companies use the term “usual and customary” when setting fee limitations on services. The term applies, but does not accurately reflect the average fees charged by physicians in our community. Please be aware, your contract benefit may state your insurer will pay a percentage of the “usual and customary fees”. Our actual charges may be higher.

Charges to account

We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

PATIENT SIGNATURE: _____ DATE: _____

Print name