

PLEASE COMPLETE THE ENTIRE FORM

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| Patient Information | | | | | | | |
| Today's Date: | | Date of Birth: | | Social Security Number: | | | |
| Legal Last Name: | | Legal First Name: | | Middle Name: | | Preferred Name: | |
| Referring Physician: | | | | Referring Physician Phone Number: | | | |
| Primary Care Physician: | | | | Primary Care Physician Phone Number: | | | |
| Patient Contact Information | | | | | | | |
| Home Address (Street, City, State, Zip): | | | | | | | |
| Mailing Address (Street, City, State, Zip): <input type="checkbox"/> Same as the home address | | | | | | | |
| Phone: Is this a cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Alternate Phone: Is this a cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Email Address: | | | | Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Email <input type="checkbox"/> Patient Portal | | | |
| Patient Demographics | | | | | | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Choose not to disclose | | | | | | | |
| Preferred Pronouns: <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> He, Him, His <input type="checkbox"/> They, them, theirs <input type="checkbox"/> Other, please describe _____ <input type="checkbox"/> Choose not to disclose | | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Genderqueer/Non-binary <input type="checkbox"/> Other, please describe _____ <input type="checkbox"/> Choose not to disclose | | Sexual Orientation: <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian, Gay, Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other, please describe _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose | | Sex (Assigned at Birth): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown | |
| Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race, please specify _____ <input type="checkbox"/> Choose not to disclose | | | | Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Choose not to disclose | | | |
| Preferred Language: | | Preferred Language for Written Documents: | | Do you need a medical interpreter at appointments at no cost? <input type="checkbox"/> Yes, specify language _____ <input type="checkbox"/> No | | | |
| Occupation and Employer: | | | | Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student (Full) <input type="checkbox"/> Student (Part) <input type="checkbox"/> Choose not to disclose | | | |



OREGON SURGICAL WELLNESS (OSW)
WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
ONCOLOGY ASSOCIATES OF OREGON
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES



PLEASE COMPLETE THE ENTIRE FORM

| Patient Information | | | |
|--|-------------------|---------------------------|--------------------------|
| Legal Last Name: | Legal First Name: | Middle Initial: | Date of Birth: |
| Billing Address (Street, City, State, Zip): | | | |
| Primary Insurance Information | | | |
| Company: | Subscriber Name: | Subscriber Date of Birth: | |
| Group Number: | | ID/Policy Number: | |
| Secondary Insurance Information | | | |
| Company: | Subscriber Name: | Subscriber Date of Birth: | |
| Group Number: | | ID/Policy Number: | |
| Tertiary Insurance Information | | | |
| Company: | Subscriber Name: | Subscriber Date of Birth: | |
| Group Number: | | ID/Policy Number: | |
| Assignment of Benefits, Authorization to Release Medical Information: | | | |
| <p>I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by Oregon Surgical Wellness (OSW), and I hereby assign to WVCI all assignable rights to payment for services rendered by OSW, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by OSW, WVCI, other providers, and insurers for treatment, payment and healthcare operations purposes.</p> <p>I understand that in order for OSW/WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that OSW/WVCI may request and use my prescription history from other healthcare providers or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize OSW/WVCI to obtain my prescription history.</p> | | | |
| FINANCIAL AGREEMENT: | | | |
| I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered. | | | |
| I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original. | | | |
| THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING | | | |
| Patient Signature: | | | Relationship to Patient: |
| (for patients 17 years of age or younger, parent or guardian MUST sign) | | | |
| Printed Name: | | Date: | |

STAFF USE ONLY

RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

AUGUST 2023 VERSION 1.1



OREGON SURGICAL WELLNESS (OSW)
 WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
 ONCOLOGY ASSOCIATES OF OREGON
 NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



Oregon Surgical Wellness (OSW), a division of Willamette Valley Cancer Institute and Research Center (WVCI), has a responsibility to protect the privacy of your health care information. OSW also has a responsibility to give a Notice of Privacy Practices that describes:

- how your health care information may be used and shared
- how you can get your health care information
- whom to reach if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time. You may call OSW at **541-735-3778** to get an up-to-date copy of the notice or to ask questions. **This form will be retained in your records.**

By my signature below, I agree that I have received the Notice of Privacy Practices of Oregon Surgical Wellness:

Printed Patient Legal Name – First, Middle, Last

| | | |
|---|------|------|
| Signature of Patient or Patient's Personal Representative | Date | Time |
|---|------|------|

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

| | | |
|---------------------------------|-------------------------|--------------|
| Name of Personal Representative | Relationship to Patient | Phone Number |
|---------------------------------|-------------------------|--------------|

| FOR INTERNAL USE ONLY | |
|---|---------------------------|
| <i>If acknowledgment was not obtained, please state the reason:</i> | |
| | |
| | |
| PRINTED OSW EMPLOYEE NAME | SIGNATURE OF OSW EMPLOYEE |

STAFF USE ONLY
 RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK
 AUGUST 2023 VERSION 1.1

User Electronic Mail Authorization Form
Patient Portal: Ontada Health®

Ontada Health®, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Ontada Health® Portal. **Please look for an email from Ontada Health® promptly after submitting this form.**

For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Ontada Health® Portal the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name
(First Name, Middle Initial, Last Name)

Email Address of Patient/Authorized User

Date of Birth of Patient

Physician's Name

Authorized User is:

- Patient
 Patient's Designee

Patient's Designee's Name (Printed)

Patient's Designee's Signature

Patient's Medical Record Number

Patient's Signature

Date

Signature of Practice Staff
[confirming user's identity and authority]

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient

STAFF USE ONLY

RECEIVING STAFF INITIALS: _____

PATIENT MRN: _____

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

PATIENT DECLINED PORTAL ACCESS

EMAIL IN PMS OR IKM

SEPTEMBER 2023 VERSION 1.1

3rd PARTY ACCESS NO YES

PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

Patient Legal Name (First, Middle Initial, Last)

Date of Birth

Phone Number (Home/Cell)

Phone Number (Work)

1. Alternate Contact Information Authorization

| | | | |
|-------------------------------|---|---|---|
| WVCI has my authorization to: | Leave medical information on my home/cell voice mail | Y | N |
| | Contact me at my place of employment | Y | N |
| | Leave medical information on voice mail at my place of employment | Y | N |

2. Family / Friends Release of Information Authorization

I authorize WVCI to speak with, and verbally disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services.

Please note: This form supersedes the information provided on previous forms.

| | | | |
|------|-------------------------|--------------|---------------------------|
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |
| Name | Relationship to Patient | Phone Number | Y N Emergency Contact? |

3. Validation and Signature

I understand that I can change this list at any time by notifying WVCI in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.

Signature of Patient

Date

***If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:**

Name of Personal Representative

Relationship to Patient

Today's Date: _____ **Patient Name:** _____ **Date of Birth:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Personal Medical History: Have you ever been diagnosed with the following? (Please check)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Alcohol/Drug dependence |
| <input type="checkbox"/> Heart Disease/CHF | <input type="checkbox"/> Migraines | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Pancreatic disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Lupus/autoimmune |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Asbestos Exposure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin ulcers |

Other: _____

Surgical History: List operations you have had and the reason for surgery. Please give approximate date and list in chronological order, if possible, including tonsils, C-Sections, etc.

1. _____
2. _____
3. _____
4. _____

Hospitalizations, Serious illness, and injuries: Please give approximate date and list in chronological order if possible.

1. _____
2. _____
3. _____
4. _____

Have you had a blood transfusion? Yes No

Family History:

| Relationship | Please circle | Age | If Deceased: Age at Death and Cause of Death | Significant Medical History |
|-------------------|----------------|-----|---|-----------------------------|
| Father | Alive Deceased | | | |
| Mother | Alive Deceased | | | |
| Sibling 1: | Alive Deceased | | | |
| Sibling 2: | Alive Deceased | | | |
| Sibling 3: | Alive Deceased | | | |
| Sibling 4: | Alive Deceased | | | |

Has any of your extended family ever had any of the following (including cousins, grandparents, aunts/uncles):

| Relationship | Maternal or Paternal | Age at Onset | History of Cancer (If yes, indicate type) | History of blood clots (If yes, where) | History of excessive bleeding (if yes, where) |
|--------------|----------------------|--------------|---|--|---|
| Grandmother | | | | | |
| Grandfather | | | | | |
| Grandmother | | | | | |
| Grandfather | | | | | |
| Aunt/Uncle | | | | | |
| Aunt/Uncle | | | | | |
| Cousin | | | | | |

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Do you have an advance directive for healthcare decisions? Yes No

Social History:

Do you use nicotine? Yes No How much/how long: _____ Quit/When: _____
 What type? Cigarettes Cigars Chew

Do you drink alcohol? Yes No How much/how long: _____ Quit/When: _____

Have you used drugs? Yes No What type: _____ Quit/When: _____

Marital Status: Single Married Domestic Partnership Divorced Widowed

Living Situation: Alone Roommate Spouse/Partner Significant Other With Children Parents

Immunizations: Please give date of most recent vaccination or series completion date.

Influenza: _____ Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____

Shingles: _____ Tetanus: _____ HPV: _____ Meningococcal: _____

Preventative Health:

Have you ever had a colonoscopy? Yes No

Date/location of last colonoscopy: _____ Findings: _____

Have you ever had bone density test? Yes No

Date/location of last test: _____ Findings: _____

Have you had a mammogram? Yes No

Date/location of last mammogram: _____ Findings: _____

FOR WOMEN

Menstrual History:

Date of last period: _____ Age periods began: _____ Age of Menopause: _____

Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? Yes No

Number of live births: _____ Number of pregnancies: _____

Current birth control method: _____ Are you interested in preserving your fertility? Yes No

Medication Allergies: List medication and reaction.

| Medication | Reaction | Medication | Reaction |
|------------|----------|------------|----------|
| | | | |
| | | | |
| | | | |

Medication List: List medication, dose and how often you take it. Include non-prescriptive items and supplements.

| Name | Dose | Frequency | Name | Dose | Frequency |
|------|------|-----------|------|------|-----------|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Please review and mark any current symptoms or problems you have experienced in the last six months.

General:

- Loss of appetite
- Fever/chills
- Night sweats
- Weakness
- Fatigue

Hematologic:

- Abnormal bleeding
- Abnormal bruising
- Swollen glands

Allergies/immunologic:

- Seasonal allergies
- Food allergy _____
- Sinus Problems
- Frequent infections

Skin:

- Slow healing
- Rash
- Nail change
- Change in skin or mole
- Other _____

Breasts:

- Discharge/bleeding
- Lump
- Pain

Eyes:

- Change in vision
- Eye infection
- Eye pain

Ears/Nose/Throat:

- Hearing loss
- Ringing in ears
- Bleeding gums
- Hoarseness
- Neck swelling/lumps
- Nose bleeds
- Dental Issues

Cardiovascular:

- Chest discomfort/pain
- Irregular heart beat
- Swollen hands or feet
- Racing heart

Respiratory:

- Shortness of breath
- Cough
- Wheezing
- Cough up blood
- Difficulty breathing

Gastrointestinal:

- Bloody or black stools
- Constipation
- Difficulty swallowing
- Heartburn/esophageal reflux
- Diarrhea
- Nausea
- Vomiting
- Abdominal Pain
- Pain with bowel movements
- Jaundice

Urinary:

- Blood in urine
- Frequency
- Difficulty urinating
- Pain or burning with urination
- Incontinence

Musculoskeletal:

- Back or neck pain
- Painful or stiff joints
- Bone pain, Site: _____
- Arthritis

Mental Health:

- Depressed or sad
- Anxiety
- Sleep issues
- Suicidal thoughts

Neurological:

- Headaches
- Dizziness
- Fainting
- Loss of balance
- Difficulty speaking
- Loss of sensation
- Memory Issues
- Seizures

Endocrine:

- Weight loss
- Weight gain
- Excessive thirst
- Heat/cold intolerance

FOR WOMEN

Gynecological:

- Irregular menstrual periods
- Hot flashes
- Menopause
- Heavy menstrual bleeding