



Phone: (541) 673-2267 or Toll free (866) 836-4448

Appointment Date & Time:	Place Name Sticker Here
Referring Physician:	Family Physician:

### PATIENT HISTORY QUESTIONNAIRE

Initial  Re-Evaluation

**Race:**  American Indian or Alaska Native  Asian  African American  Pacific Islander  Caucasian  Decline to Provide

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Decline to Provide **Preferred Language:** \_\_\_\_\_

### ESCORT INFORMATION

Marital Status:  Single  Married  Separated  Divorced  Widowed  Significant Other

Spouse or Significant Other's name: \_\_\_\_\_

Who will accompany you on your first visit? \_\_\_\_\_

Do you wish to have your escort included in your initial meeting with the physician?  Yes  No

If yes, relationship and name: \_\_\_\_\_

May we discuss your medical diagnosis and treatment with your family?  Yes  No

Exclusions?  Yes  No \_\_\_\_\_

### WORK HISTORY

Occupation: \_\_\_\_\_

Are you still working?  Yes  No Hours: \_\_\_\_\_

Has your illness forced you to stop working?  Yes  No Date: \_\_\_\_\_

Do you anticipate being off work?  Yes  No Date: \_\_\_\_\_

Has your illness forced significant other to stop working?  Yes  No Date: \_\_\_\_\_

Has your illness forced significant other to change hours?  Yes  No Date: \_\_\_\_\_

### PAST SURGERIES OR HOSPITALIZATIONS List any surgeries and year performed. None

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

### OTHER MEDICAL ILLNESSES OR CONDITIONS, CURRENT OR PAST (Heart disease, diabetes, etc.)

List any and year occurred.  None

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you have a history of MRSA?  Yes  No Date: \_\_\_\_\_

Do you have any implanted devices (pacemaker, nerve stimulator)?  Yes  No List: \_\_\_\_\_

### MEDICATIONS None

List all current medications and doses including all over-the-counter, herbs, vitamins and non-prescription medications.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**HISTORY OF TOBACCO, ALCOHOL, and EXPOSURES**
**Tobacco**

 Ever use tobacco?  Yes  No  
 Currently use tobacco?  Yes  No

 How many packs per day? \_\_\_\_\_  
 What year started? \_\_\_\_\_  
 What year stopped? \_\_\_\_\_

**If yes, check type(s):**
 Cigarettes  Chew  
 Pipe  Cigars  
 Snuff

**To be completed by Nurse:**
**Total Pack Years:** \_\_\_\_\_

**Alcohol**

 Ever use alcohol?  Yes  No  
 Currently use alcohol?  Yes  No

 If yes, list type/amount? \_\_\_\_\_  
 What year started? \_\_\_\_\_  
 What year stopped? \_\_\_\_\_

**CURRENT PROGRAMS**

 Are you participating in any programs?  Yes  No

 If yes,  Smoke Cessation program  AA  Other \_\_\_\_\_

 Were you exposed to carcinogenic substances, asbestos?  Yes  No List: \_\_\_\_\_  
 Do you have a history of illegal drug use?  Yes  No List: \_\_\_\_\_

**FAMILY HISTORY OF CANCER**

Immediate	Type of Cancer	Maternal	Type of Cancer	Paternal	Type of Cancer
Mother	<input type="checkbox"/> Yes	Grandmother	<input type="checkbox"/> Yes	Grandmother	<input type="checkbox"/> Yes
Father	<input type="checkbox"/> Yes	Grandfather	<input type="checkbox"/> Yes	Grandfather	<input type="checkbox"/> Yes
Sister	<input type="checkbox"/> Yes	Aunt	<input type="checkbox"/> Yes	Aunt	<input type="checkbox"/> Yes
Brother	<input type="checkbox"/> Yes	Uncle	<input type="checkbox"/> Yes	Uncle	<input type="checkbox"/> Yes
Children	<input type="checkbox"/> Yes				

**FAMILY HISTORY**

Please check the appropriate box if there is a history of the following disease(s) in your immediate family.

 Heart Disease  High Blood Pressure  Stroke  Diabetes

List other hereditary diseases: \_\_\_\_\_

 Mother  Alive  Deceased Cause: \_\_\_\_\_ Age: \_\_\_\_\_  
 Father  Alive  Deceased Cause: \_\_\_\_\_ Age: \_\_\_\_\_  
 Children #\_\_\_\_\_Alive #\_\_\_\_\_Well #\_\_\_\_\_Natural #\_\_\_\_\_Adopted  Able to Assist

**GENERAL HISTORY**

Before my current illness, I would describe my overall health as:

 Excellent  Good  Fair  Poor

At the present time I feel:

 Excellent  Good  Fair  Poor

 Do you have a POLST for Advanced Directive?  Yes  No

**PAST CANCER HISTORY**

Have you ever had any of the following?

 Prior Cancers  Prior Radiation  Prior Chemotherapy  None Apply

 Are you taking hormonal therapy (i.e., Tamoxifen, Lupron)?  No  Yes If yes, what? \_\_\_\_\_

What other doctors have you seen for your current diagnosis? \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please ✓ any of the items that apply to you or that you may be experiencing.

**CHIEF COMPLAINT:** Please explain in your own words, the reason you are here today.

**GENERAL HISTORY**

Normal Weight: \_\_\_\_\_

 Recent Weight Loss

Amount: \_\_\_\_\_

 Recent Weight Gain

Amount: \_\_\_\_\_

 Loss of appetite

 Fatigue

 Weakness

 Fevers

 Chills

 Night sweats

 Sleep problems

**EYES**
 Glasses

 Contact Lenses

 Glaucoma

 Cataracts

 Double vision

 Change in vision

 Other vision problems

**EARS/NOSE/THROAT**
 Loss of hearing

 Hearing aid

 Ringing in ears

 Other ear problems

 Dentures

 Dental problems

 Frequent sore throats

 Hoarseness

 Difficulty swallowing

 Dry mouth

 Loss of taste

 Neck stiffness

 Neck pain or swelling

**CARDIOVASCULAR**
 Pacemaker

 Chest pain

 Irregular heartbeat

 Palpitations

 Hypertension

 Sleep sitting or propped up

 Short breath when lying down

 Fainting spells

 Leg pain while walking

 Swelling in feet

 Varicose veins

 Oxygen use at home

**RESPIRATORY**
 Shortness of breath

**ALLERGIES:** \_\_\_\_\_

**PAIN**

 Do you currently have any pain?  Yes  No If yes, where? \_\_\_\_\_

Please circle your current pain rating on a scale of 1-10 (1 being the best, or no pain. 10 being the worst, or intolerable).

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

 Do you take medication for this pain?  Yes  No List: \_\_\_\_\_

 Is this medication effective for your pain?  Yes  No

 Difficulty breathing

 Coughing

 Dry cough

 Coughing up sputum

 Coughing up blood

**GASTROINTESTINAL**
 Heartburn

 Nausea/upset stomach

 Abdominal pain

 Vomiting

 Jaundice

 Change in bowel habits

 Constipation

 Diarrhea

 Blood in stool

 Hemorrhoids/fissures

**GENITOURINARY**
 Difficulty urinating

 Frequent urination

 Painful urination

 Up at night to pass urine

 Blood in urine

 Color change of urine

**WOMEN ONLY**

Age of Menarche \_\_\_\_ Age of Menopause \_\_\_\_

Date of last menstrual period: \_\_\_\_\_

Date of last pelvic exam: \_\_\_\_\_

Date of last pap: \_\_\_\_\_

 Hot flashes

 Hormone therapy

 Currently sexually active

Is there a chance you may be pregnant?

 Yes  No

\_\_\_\_ # of pregnancies \_\_\_\_ # living

**MEN ONLY**
 Impotence

 Difficulty with erections

 Penile discharge

 Testicular mass

 Testicular pain

**MUSCULOSKELETAL**
 Leg cramps

 Painful muscles

 Painful joints

 Artificial joints

 Physical disabilities

 Gout

**SKIN & BREAST**
 Itching

 Blotchy

 Rash

 Scaling

 Sores

 Color changes

 Pain in breast

 Growths

 Lump or mass in breast or armpit

 Discharge or bleeding from nipple

 Change in nipple

 Nipple inversion

 Change in size, shape or contour of breast

**NEUROLOGICAL**
 Headaches

 Tremors

 Memory loss

 Difficulty finding words

 Difficulty writing

 Difficulty thinking clearly

 Numbness or tingling

 Dizziness

 Loss of consciousness

 Seizures

 Coordination

 Unsteady gait

**PSYCHIATRIC**
 Nervousness

 Anxiety

 Depression

 Change in personality

 Relationship problems

**ENDOCRINE**
 Excessive thirst

 Excessive urination

 Thyroid problems

**HEMATOLOGIC & LYMPHATIC**
 Swollen lymph glands

 Excessive bruising

 Excessive bleeding

**ALLERGY & IMMUNOLOGY**
 Medications

 Latex allergies

 Food or non-medication allergies

 Tape allergies

 Hay Fever

 None

**ENERGY**

- Independent
- Maintain ADLs
- Weakness
- # hrs sleep per night \_\_\_\_\_
- # hrs sleep per day \_\_\_\_\_
- Does own cooking

**MOBILITY**

- No difficulty
- Weakness
- Unsteady
- Falls
- Paralysis \_\_\_\_\_

**USES**

- None
- Cane
- Crutches
- Walker
- Wheelchair

**NEEDS ASSISTANCE WITH:**

- Bathing
- Dressing
- Ambulation
- Feeding
- Transfers
- Stand-by assist
- 2-person assist

**NUTRITIONAL SCREEN**

- Without trying, have you lost or gained 10 pounds in the last 6 months?  Yes  No
- Do you have an illness or condition that made you change the kind and/or amount of food you eat?  Yes  No
- Do you eat at least 2 meals per day?  Yes  No
- Do you eat at least 3 fruits or vegetables or 3 milk products per day?  Yes  No
- Do you have 3 or more drinks of beer, liquor or wine almost every day?  Yes  No
- Do you have tooth, mouth or swallowing problems that make it hard for you to eat?  Yes  No
- Do you have enough money to buy the food you need?  Yes  No
- Do you eat alone most of the time?  Yes  No
- Do you take 3 or more different prescribed or over the counter drugs a day?  Yes  No
- Are you physically unable to shop, cook and/or feed yourself and have no one available to help?  Yes  No

**CURRENT LIVING ARRANGEMENTS**

- Independent
- Live Alone
- Lives with other(s)
- Assisted Living
- Nursing Home

Number living in house \_\_\_\_\_ Relationship(s) \_\_\_\_\_

What floor does patient live on? \_\_\_\_\_ Does the patient feel their living environment is safe?  Yes  No

Has the diagnosis of cancer forced a change in the patient's usual living situation?  Yes  No

Describe \_\_\_\_\_

**PRINCIPAL SUPPORT PERSON**

Name: \_\_\_\_\_ Health Issues of Principal Support Person That May Affect Care  None

Describe: \_\_\_\_\_

**EXTENDED FAMILY/FRIENDS SUPPORT** (who would be available to drive, help around home if necessary)

\_\_\_\_\_

**OTHER SUPPORT RESOURCES** (Church, club affiliations, etc.)

\_\_\_\_\_

- Senior Services
- Meals on Wheels
- Home Health or Hospice services
- Senior Companion
- Disability Service (Caseworker \_\_\_\_\_)
- Other: \_\_\_\_\_

Is your support system adequate to fit your needs?  Yes  No

Describe \_\_\_\_\_

**FUNCTIONAL STATUS**

Does patient exercise regularly?  Yes  No Type of exercise/frequency? \_\_\_\_\_

Does patient drive?  Yes  No Does patient have a vehicle available for transport?  Yes  No

If patient is continuing to work, what are work hours? \_\_\_\_\_

**FINANCIAL STATUS**

Insurance \_\_\_\_\_  No insurance (refer to CCC Financial Counseling)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



Patient Name: \_\_\_\_\_

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

**PATIENT SELF-ASSESSMENT**

By placing a check in one box in each group below, please indicate which statements best describe your own health state today.

**Mobility**

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

**Self-Care**

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

**Usual Activities** (e.g. work, housework, family, leisure activities)

- I have no problems with doing my usual activities
- I have some problems with doing my usual activities
- I am unable to perform my usual activities

**Pain/Discomfort**

- I have no pain and/or discomfort
- I have mild pain and/or discomfort
- I have moderate pain and/or discomfort
- I have severe pain and/or discomfort

**Anxiety/Depression**

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

Please draw a single circle or mark on the scale on the right (from 0 to 100) to demonstrate how you feel your overall health is today.

Best imaginable health state

100

90

80

70

60

50

40

30

20

10

0

Worst imaginable health state

Please list all vitamins/dietary supplements, with dosage and amount you currently taking



Name of dietary supplement .	<u>Dosage</u> mg or ml	Taking daily? weekly?

Patient name: \_\_\_\_\_

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

Due to increased healthcare rules and regulations, please list all parties involved in your care or payment of care to which we may speak to or leave a message with regarding your healthcare, appointment scheduling, and payment.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

May we contact you at work?     Yes     No

May we leave a message on your answering machine?     Yes     No

Period for this consent is:     From \_\_\_\_\_ to \_\_\_\_\_; **or**  
 Lifetime or until notified

By signing below, I consent to Community Cancer Center's disclosure of information about my healthcare, appointments and payment to the above-named parties.

_____	_____
Patient Signature	Date
_____	
Printed Name	

**NOTICE OF PRIVACY PRACTICES**  
for Community Cancer Foundation dba  
**COMMUNITY CANCER CENTER**

*Revision Date: April 17, 2017*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*If you have any questions about this notice, please contact the Privacy Officer of our office at (541) 673-2267.*

**WHO WILL FOLLOW THIS NOTICE.** This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

**YOUR MEDICAL INFORMATION.** We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.** The following categories describe different ways that we use and disclose medical information. “Use” is what we do with your information in this office. “Disclose” means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations.** We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
  - The Community Cancer Center participates in multiple internet-based health information exchanges. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may opt out and prevent searching of your health information available through the health information exchange by calling 541-673-2267, or completing and submitting an Opt-Out form to the Community Cancer Center, 2880 NW Stewart Parkway, Set 100, Roseburg, OR 97471.
- **To the Department of Health and Human Services (HHS).** We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You.** We must disclose your medical information to you when you request it in writing, as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object.** We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider’s professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use.** Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization.** We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities.** We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent’s permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers’ compensation or similar programs.
- **Law Enforcement.** We may disclose your Health Information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set.** In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.



- **Fundraising.** We may disclose certain medical information about you for fundraising purposes. We may also contact you for fundraising purposes. If you do not wish to be contacted for this purpose, you may opt out of receiving such communications.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information.** Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other.** Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office. To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request** unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach.** You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## Patient Acknowledgement and Consent *for Health Information Disclosure, Evaluation, Treatment, and Billing*

1. I understand that Community Cancer Foundation, dba Community Cancer Center and Roseburg Oncology, P.C. (referred to below as “this Practice”) will use and disclose **health information** about me as described in the **Notice of Privacy Practices** provided to me. I have received a copy of the **Notice of Privacy Practices** and have reviewed and understand the information included in it.
2. I grant permission for this Practice (including Randy L. Moore, D.O., Michael L. Brown, M.D., Scott Moore, PA-C) or their designate to evaluate and/or treat the above named patient.
3. For Radiation Oncology patients: This Practice participates in Cancer Registry by providing your radiation treatment information to the facility where you were diagnosed. I consent to this Practice’s disclosure of health and medical information for the purposes of Cancer Registry.
4. I authorize payment to be made to this Practice for services provided.
5. As a courtesy, we will bill your primary, and one secondary, insurance. However, payment will be expected in full from the patient within 30 days after the patient’s responsibility has been determined, unless other payment arrangements have been made. If the provider is PARTICIPATING with my insurance carrier, I am only responsible for deductibles, co-insurance, and any non-covered services. If the provider is NON-PARTICIPATING with my insurance carrier, I am responsible for my account in full. Those patients undergoing radiation therapy will have individual financial counseling during their treatment period with estimated patient responsibility presented.

By signing below, I agree that I have reviewed and understand the information above.

By: _____ (Patient Signature)	Date: _____
_____	
(Printed Name)	

-OR-

By: _____ (Patient Representative)	Date: _____
_____	
(Printed Name)	
Description of Representative’s Authority: _____	

**COMMUNITY CANCER CENTER & ROSEBURG ONCOLOGY, PC  
PATIENT AUTHORIZATION FOR ELECTRONIC HEALTH RECORDS**

To provide better care to its patients **Community Cancer Center and Roseburg Oncology, PC** (collectively referred to as “the Practice”) has chosen to participate in an electronic health records system called “Umpqua One Chart.” Under this system, each patient has a single, secure set of electronic information that can be accessed by participating physicians and other providers from their offices, urgent care facilities, the emergency room, the hospital, and other locations. Among its many benefits, this system:

- allows immediate access to results of tests, imaging procedures, and other potentially critical information for routine and emergency treatment;
- allows the coordination of prescriptions and care by multiple providers;
- provides Patient and Patient’s physicians or other providers with reminders and information from national health treatment databases;
- reduces chances of error and otherwise improves the quality of care Patient receives; and
- helps in the processing of insurance and other claims.

The Practice recognizes the importance of keeping Patient’s individual information confidential. Accordingly, Umpqua One Chart has, through contracts and strict rules, limited access to individual information to health care providers and those providing assistance to them, and only for the purposes of providing health care and related activities. Patient privacy is also protected by state and federal law.

I authorize the Practice to include my health information in the Umpqua One Chart for the purpose of providing me with high quality, efficient, and fully informed health care. The health information to be included with my shared health information includes all information in my health records relevant to the above-described purpose, and includes records created by the Practice after the date of this authorization.

By initialing each category, I specifically authorize you to include information about testing, diagnosis, treatment and related information about the following kinds of problems in my records:

_____ HIV/AIDS	_____ Mental Health
_____ Genetic Testing	_____ Drug/Alcohol

Unless revoked earlier, this authorization shall remain in effect until my death.

**Note:**

- (1) \*You have the right to revoke this Authorization at any time, provided that you do so in writing. If you do so, we will stop entering your health-related information in Umpqua One Chart. To revoke this authorization, please contact our Privacy Officer;
- (2) \*We cannot condition our provision of services or treatment to you on the receipt of this signed authorization; and
- (3) \*I also understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

**Dated** \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
**Patient or Guardian Signature (circle one)**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Printed Name of Above and Relationship**