CASCADE SURGICAL ONCOLOGY, PC

Office Policy and Financial Agreement

In the interest of good health care practice, it is desirable to establish an office policy and financial agreement to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

You will be asked to provide our office with your health insurance card (if applicable). If you do not have insurance, you are expected to pay the balance in full at the time of service.

- Insurances will be billed by Cascade Surgical Oncology. It is the responsibility of the patient to verify that the office has their correct insurance information and/or to inform the office if there are any changes with their insurance provider, including changes in policy/group numbers. Remember, an insurance policy is a contract between the patient, the patient's employer and/or the insurance carrier. ***Ultimately the PATIENT is responsible for the timely payment of their account. All applicable co-pays are due at the time of service.***

- Although we will attempt to call you before your scheduled appointment, this call is only a friendly reminder and patients who schedule their appointment will be expected to keep their appointment whether or not they received a courtesy call by our office. We are happy to reschedule your appointment, if needed; just call our office. However, we *will charge a $50.00 fee for missed appointments and for appointments not canceled within 24 hours.*

I have read this *Office Policy and Financial Agreement* and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I agree to pay a $12.00 late fee on patient balances over 90 days. I also understand that delinquent accounts may be assigned to a credit reporting collection service and I will be charged a $50.00 collection fee. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. There is a $1.00 fee for payments processed via credit card.

I authorize payment directly to Cascade Surgical Oncology, PC by the insurance carrier, group or personal benefits or any other insurance otherwise payable to me for medical services rendered by Cascade Surgical Oncology. I authorize Cascade Surgical Oncology to release any medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted, and to release credit information to appropriate information gathering services.

I understand if I do not have insurance, or do not notify the office of insurance in a timely manner, I am responsible for the balance of all charges incurred with Cascade Surgical Oncology.

I agree whether I sign as patient or responsible party, which in consideration of the medical services rendered to the patient, I hereby individually obligate myself to pay the account of Cascade Surgical Oncology, PC.

Patient Name (Print) Last: _____ First_____ DOB_____

Patient Signature:_____ Date:_____

CASCADE SURGICAL ONCOLOGY, PC
(541) 302-6469
ACKNOWLEGEMENT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand the *Notice of Privacy Practices* that outlines that *Cascade Surgical Oncology, PC* may:

- Disclose my information for *treatment purposes and to coordinate my medical care.*
- Disclose my information *to ensure that I receive insurance benefits*
- Disclose my information internally *to enhance the operation of its practice.* This includes Cascade Surgical Oncology's commitment to reviewing the quality of care that is provided.
- Disclose my information *to comply with a limited number of legal requirements,* as outlined in the *Notice of Privacy Practices,* effective September 23, 2013.

I understand that additional information regarding each of the above disclosures is provided in the full *Notice of Privacy Practices* that has been provided to me on this date, and that only the minimum amount of information necessary will be disclosed for the purpose it was requested.

I understand that I have the right to request a secure copy of my medical records electronically.

_____ _____

Patient Signature **Date**

Medical Release of Information

Please list any family members and/or friends with whom we can share information with. Please identify the information we are authorized to discuss:

1. ☐No one

2. Emergency Contact Name_____Number_____Relationship:_____

☐Appointment information ☐ Medical and treatment information ☐ Financial information

3. Name_____ Relationship_____

☐Appointment information ☐ Medical and treatment information ☐ Financial information

4. Name_____ Relationship_____

☐Appointment information ☐ Medical and treatment information ☐ Financial information

5. Name_____ Relationship_____

☐Appointment information ☐ Medical and treatment information ☐ Financial information

_____ _____

Patient Signature **Date**

CASCADE SURGICAL ONCOLOGY, PC

Medical History

_____ _____ _____ _____

Last Name **MI** **First Name** **DOB** **Age** **Today's Date**

Gender? ☐ **Male** ☐ **Female** **Employer**:_____

Referring Provider:_____City/State: _____
(please note MD, PA or DO)

Primary Care Provider:_____ City/State**:**_____
(please note MD, PA or DO)

Pharmacy/Location:_____

Why are you here today? (Chief Complaint)

_____

Please list any medical illnesses (ie, Diabetes, Asthma, Heart Problems) _____

_____

Any family history of cancer? If yes, who and what type? _____

_____

Have you been a smoker? ☐ Yes ☐ No **If yes, when?** _____

Alcohol? _____ **Drinks per day?**_____ **Per week?**_____

Surgery	Reason for Surgery	Year

Do you take any herbal supplements? ☐ Yes ☐ No **If so, what type**?

_____

Are you allergic to iodine? ☐ Yes ☐ No **Are you Claustrophobic?** ☐ Yes ☐ No

List allergies to any medications?

_____

Medications/Reason for Medication

If you have a medication list from your primary care provider, please bring that with you to your appointment. Otherwise, please list the medications (both prescription and over-the-counter) that you are currently taking. Please include strength (ie: “mg”) and dosage (ie: “2 tablets twice a day”)

MEDICATION	REASON FOR TAKING MEDICATION