Dr. Marilyn B. Sandford
Alaska Breast Care and Surgery, LLC
3851 Piper Street U 462
Anchorage, AK 99508
Phone: 562-6262; Fax: 562-6267

Patient Information

Patient Last Name:	First Name:	M.I.
DOB: / SSN:	Home Phone:	
Mailing Address:	Cell Phone:	
City: / State: / Zip Code:	Work Phone:	
Local Contact # (if from out of town):	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated	
Patient Employer:	Patient Occupation:	
Spouse/Partner or Parent Name:	Contact Number:	
Spouse/Partner/Parent Employer:	Work Number:	
Referring Physician:	Primary Care Physician:	

Billing Information

Primary Insurance Company:	Name of Subscriber:
Policy #:	Group #:
Secondary Insurance Company:	Name of Subscriber:
Policy #:	Group #:

Ethnicity - Race – Language

Do you consider yourself Hispanic or Latino?	***What category best describes your race? (You may choose more than one.)***	***What language do you prefer speaking with your health care provider?***
□ I am Hispanic or Latino. □ I am not Hispanic or Latino. □ I don't know. □ I decline to answer.	□ White or Caucasian □ Black or African American □ Asian □ Native American or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Other _____ □ Unknown □ I decline to answer.	□ English □ Spanish □ Russian □ Other _____

Financial Agreement and Authorization for Treatment

My signature authorizes treatment and I agree to pay all fees and co-payments for services not covered by my health care plan. I understand that all charges are my responsibility regardless of insurance coverage and that co-pays are due at the time of service. Fees are due and payable in full within thirty (30) days following the statement closing date.

I hereby authorize the release of any information required to process my insurance claim(s).I hereby authorize my insurance benefits to be paid directly to Alaska Breast Care and Surgery, LLC.

Signature:	Date:
Patient Name:	Date of Birth:

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Release of Personal Health Information
Family and Friends

Please list below, any **family or friends** *to whom we may release information should they contact our office regarding your medical condition.*

I authorize Alaska Breast Care and Surgery, LLC to release my personal health information (PHI) to the following- Please list phone numbers in the event that we need to contact these people.

1. _____ Relationship: _____ Phone Number:_____

2. _____ Relationship: _____ Phone Number:_____

3. _____ Relationship: _____ Phone Number:_____

4. _____ Relationship: _____ Phone Number:_____

By signing below, I agree that Alaska Breast Care and Surgery, LLC may release my PHI to the abovementioned individual(s). I understand that I may revoke this authorization at any time by providing a written notice of revocation to the Privacy Officer at the address indicated below. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will not expire.
If you wish that this authorization expire, please specify a specific expiration date:
_____/_____/_____

Privacy Officer
Alaska Breast Care and Surgery, LLC
3851 Piper Street, Suite U-462
Anchorage, AK 99508

Your request will be processed within 48 hours unless otherwise specified. Please call (907) 562-6262 if you have additional questions.

Signature:	Date:
Printed Name:	

Privacy Policy
I acknowledge receipt of Alaska Breast Care and Surgery, LLC's Privacy Practice Policies related to HIPAA.

Signature:	Date:
Printed Name:	

Dr. Marilyn B. Sandford
Alaska Breast Care and Surgery, LLC
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Patient Notice of Billing Practices

Medical Services provided by Alaska Breast Care and Surgery, LLC are payable at the time of service. We accept the following:

- Cash, Personal Checks, Money Orders, Debit Cards, MC, and Visa
- Insurance is billed as a *courtesy* for our patients**.** We do collect office visit payments at the time of the visit. **For all procedures done in the office, your co-pay is payable at the time of service; for all surgeries, 20% of the estimated fee is payable at the time the procedure is scheduled.**
- Payment plan options are offered for certain circumstances. If you are in need of a payment plan option, please ask to speak to the Practice Manager or Billing Department Supervisor. All patient payments under $500 are to be paid in full within ***three*** months. Payment plans over $1000 are to be paid in full within ***six*** months.

Our preference is to work with our patients as much as possible; however, any delinquent account balances will be forwarded to Cornerstone Credit Services. Accounts referred to a collection agency may be assessed additional fees. These fees are assessed by the collection agency and are in addition to the clinic fees due Alaska Breast Care and Surgery, LLC. All NSF checks will be assessed a $25.00 NSF fee.

Private Insurance

We bill most private policies as a courtesy to our patients. We allow a 30-day grace period for insurance companies to respond to submitted claims. If an insurance company does not respond to a submitted claim within 30 days, the amount of that claim becomes due in full by the patient. The patient is also responsible for all balances not paid by the insurance companies.

*****No Show/Cancellation Policy*****

We strive to see patients in our office as soon as possible. So that everyone can be seen in a timely fashion, we ask that you contact our office at least 2 business days before your appointment if you need to cancel and reschedule. If you fail to contact our office 24-hours in advance or if you do not show for your appointment, you will be assessed a $25.00 fee.

Medicare/Medicaid

We accept Medicare and Medicaid. As a provider participating in the Medicare and Medicaid programs, we are required to collect applicable co-payments *at the time of service*. If we believe a procedure may not be a covered service under either of these programs, we will provide you with this information and the estimated fees prior to the procedure. In such cases, you will be asked to sign a waiver indicating you understand that the procedure may not be covered and that you will be responsible for the fees associated with the procedure should your health care benefits not cover the fees.

Out of State Patients

Patients who are visiting Alaska or are foreign exchange students and require our services will be required to make full payment at the time services are rendered. We will provide you with a receipt that you may submit to your insurance for reimbursement.

Municipality of Anchorage Ordinance 2017-26

As directed by Municipality of Anchorage Ordinance 2017-26, we are more than happy to provide you with an estimate of your services should you request it. In addition to charges incurred at our office, there may be additional charges from other facilities, such as pathology, hospital facility fees, radiology fees, etc. These fees will only be assessed as appropriate to your visit. In the case of those with out of network insurance carriers, you may incur out of network charges. Please feel free to ask for our office manager if you have any questions concerning MoAO2017-26.

I have read the above payment options and understand my financial responsibility to Alaska Breast Care and Surgery, LLC. (If you have additional questions, please ask to speak to the Practice Manager prior to your appointment.) Thank you for allowing us to be part of your health care!

_____ _____

Patient or Guardian Signature Date Signed

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Consent for Photographing for Security and/or Health Care Operations

____ (Patient/Representative initials) ***I consent*** to photographs and images of me being recorded for the practice's health care operations purposes (e.g. tracking of cosmetic outcomes in surgical patients). Surgical photos will be limited to the torso. I understand that the facility retains the ownership rights to the images. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. These images will be securely stored and protected. Images in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative initials) ***I do not consent*** to photographs and images of me being recorded for the practice's health care operations purposes (e.g. tracking of cosmetic outcomes in surgical patients).

Consent to Text Messaging for Health Care Communications

Patients in our clinic may be contacted via text message by their provider to provide general health reminders/information. I understand that once I have consented to receive communication via text, I still have the right to revoke that consent at any time.

The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your carrier for pricing and plans).

Please be advised that our providers may send or receive text messages, phone calls, faxes, etc. regarding my treatment plan with other providers involved in my care.

____ (Patient/Representative initials) ***I consent to receive text messages*** from the practice at my cell phone. I understand that this request to receive text messages will apply unless I request a change in writing (please see revocation section below.)

The cell phone number I authorize to receive text messages is _____

OR

___ (Patient/Representative initials) I decline to receive text messages for health care information from my provider.

If you have previously consented to receive communication via text message and wish to remove the consent, please contact our office and we will update your account preferences to reflect this change.

Signature:	Date:
Printed Name:	

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Past Medical History

Name: _____ DOB: _____

Medicines Prescribed by your Physician

Please list all the medications you are currently taking.

Name of Medication	Dose	How often you take it

Over-the-counter Medications/Supplements

Name of Medication	Dose	How often you take it

Allergies to Medications: What medications are you allergic to and what happens if you take them?

Medication	Reaction

Latex Allergy? Y N **Other Contact Dermatitis? _____**

Please place an **X** in the box in front of all the conditions with which you have been diagnosed:

Cancer

☐	Brain		☐	Lung		☐	Thyroid
☐	Breast		☐	Lymphoma		☐	Other
☐	Cervical		☐	Ovarian			
☐	Colon		☐	Prostate			
☐	Leukemia		☐	Skin, Malignant Melanoma			

Heart and Blood Vessels

☐	Angina (Chest pain)		☐	Heart attack		☐	Peripheral vascular disease
☐	Cardiomyopathy		☐	Heart valvular disease		☐	Deep vein thrombosis (blood clots)
☐	Congestive heart failure		☐	High blood pressure			
☐	Coronary artery disease		☐	Irregular heartbeat requiring treatment			

Lungs and Respiratory

☐	Asthma		☐	Pneumonia		☐	Have you been prescribed Bi-PAP or CPAP for sleep? Yes No
☐	COPD/Emphysema		☐	Pulmonary embolism			
☐	Tuberculosis		☐	Sleep apnea			

Stomach and Digestive

☐	Diverticulosis		☐	Hepatitis		☐	Cirrhosis
☐	Crohn's Disease/Ulcerative colitis		☐	Stomach ulcer			
☐	GERD/Acid reflux		☐	Pancreatitis			

Bones, Joints, and Muscles **Skin**

☐	Arthritis (Osteo)		☐	Osteopenia		☐	Eczema
☐	Arthritis (Rheumatoid)		☐	Osteoporosis		☐	Keloid
☐	Gout					☐	Psoriasis

Brain and Nervous System

☐	Restless leg syndrome		☐	Stroke (CVA)		☐	Multiple sclerosis
☐	Peripheral neuropathy		☐	TIA's (small stroke)			

Mental and Emotional Health

☐	Anorexia/Eating disorder		☐	Depression		☐	Schizophrenia
☐	Bi-polar manic-depressive		☐	Panic attacks			
☐	Sexual abuse			If you have been sexually abused, are you in a safe situation now? ☐ Yes ☐ No			

Endocrine **Allergies, Immune/Autoimmune**

☐	Diabetes		☐	Anaphylaxis		☐	Scleroderma
☐	Hypothyroid		☐	AIDS/HIV		☐	Lupus
☐	Thyroid nodule		☐	Fibromyalgia			

Problems with Anesthesia

☐	Hyperthermia		☐	Excessive nausea		☐	Other:

Serious Injury

☐	Concussion		☐	Other:

Tests and Immunizations (Please date your *most recent* of the following to the best of your ability)

☐	Influenza Vaccination		Date:
☐	Mammogram		Date:
☐	Pap Test		Date:
☐	Colonoscopy		Date:

Surgeries/Year of Surgery

If there are any additional surgeries that are not listed below, please ensure to list them in the "Other" boxes.

☐	Tonsillectomy Year:		☐	Cataract removal Side: **R L Bilateral** Year:		☐	Brain Year: What type?
☐	Gallbladder Year: Laparoscopic OR Open technique (circle one)		☐	Appendectomy Year:		☐	Sinuses Year: What type?
☐	Ear Year: What type?		☐	Thyroid removal Year: Total OR Partial (circle one) Left OR Right (circle one)		☐	Lung Year: For what? What type?
☐	Breast Side: **R L Bilateral** Year: What type?		☐	Hysterectomy Year: Vaginal OR Abdominal (circle one) Ovaries retained: Yes No		☐	Joints Year:
☐	Bypass surgery of the heart arteries Year:		☐	Heart valves Year:		☐	Other: Type: Year:
☐	Spine Year: What type?		☐	Prostate Year:		☐	Other: Type: Year:

Family Cancer History

Please list any family members diagnosed with cancer. Be sure to include their diagnosis, their age when they were diagnosed, and whether they were a maternal or paternal relative. Please make sure to include grandparents, cousins, aunts, uncles, etc....

Example: Paternal Aunt diagnosed with breast cancer at age 45

_____
_____
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_____
_____

Have you or any member of your family ever been tested for hereditary risk of cancer? θ Yes θ No
If yes, please explain: _____

Review of Symptoms

Please an "X" by any current problems you have as listed below. Thank you.

Constitutional
_____ Decreased energy
_____ Fever/chills
_____ Unexplained weight gain
_____ Unexplained weight loss

Eyes
_____ Vision changes not corrected by glasses/contacts

Ears
_____ Dizziness
_____ Hearing loss
_____ Ringing in ears

Nose
_____ Nosebleeds, frequent

Mouth
_____ Gums in poor condition
_____ Teeth in poor condition

Cardiovascular
_____ Chest pain/discomfort
_____ Irregular heart beat

Respiratory
_____ Cough, non-productive
_____ Cough, productive
_____ Shortness of breath/difficulty breathing

Neurological
_____ Difficulty remembering
_____ Difficulty with coordination
_____ Headaches
_____ Numbness
_____ Seizures

Allergic/Immunologic
_____ Seasonal rhinitis (runny nose)

Gastrointestinal
_____ Abdominal pain
_____ Blood in stool
_____ Diarrhea
_____ Nausea
_____ Vomiting

Genitourinary
_____ Decreased interest in sex/decreased sexual drive
_____ Unusual menstrual bleeding
_____ Painful sex
_____ Vaginal dryness
_____ Blood in urine
_____ Difficulty holding urine

Musculoskeletal
_____ Painful joints
_____ Pain when using muscles

Skin & Breast
_____ Discharge from nipple
_____ Breast masses or lumps
_____ Breast pain
_____ Skin rash

Hematologic/Lymphatic
_____ Bleeds excessively after injury or minor surgery
_____ Bruises easily
_____ Masses/lumps in armpit
_____ Masses/lumps in groin
_____ Masses/lumps in neck

Psychological
_____ Feels nervous/anxiety
_____ Feels sad more than usual (depressed)
_____ Trouble sleeping

Social History

Occupation: _____

Marital Status:
_____ Single _____ Married
_____ Divorced _____ Widowed _____ Separated

Tobacco Use:
Cigarettes: Never _____ Quit: Date ____/_____/_____

Current: Packs per day _____ Date started: ___/___/____

Caffeine Intake: (tea, chocolate, soda, coffee, etc.)
_____ None
_____ About 1 caffeinated product per day
_____ About 2-3 caffeinated products per day
_____ 4 or more products per day

Alcohol Use:
Do you drink alcohol? Yes No
_____ Less than 12 drinks per year
_____ 1-13 drinks per month
_____ 4-14 drinks per week
_____ Greater than 2 drinks per day

Special Interests: _____

_____

_____

Risk Assessment:

1. How old were you when you had your first menstrual cycle? _____
2. Menopausal status? _____ If postmenopausal, what age was menopause? _____
3. How many pregnancies have you had? _____ How many live births? _____
4. Did you breast feed? _____ If so for how long? _____
5. How old were you when you had your first child? _____
6. Have you had any breast biopsies? _____ When? _____ On which breast? _____
7. Did your biopsy come back abnormal? _____
8. Has anyone in your family had breast cancer? If so, what was their age at diagnosis and were they on Maternal or Paternal side? _____
9. Has anyone in your family had ovarian cancer? If so, what was their age at diagnosis and were they on Maternal or Paternal side? _____
10. Has anyone in your family had genetic testing? _____
11. Are you currently, or have you used hormones for menopausal symptoms? If so at what age and for how long? _____
12. Number of sisters? ____ Number of Maternal Aunts? ____ Number of Paternal Aunts? _____
13. Daughters? _____
14. Are you of Jewish ancestry? _____

HYSTERECTOMY

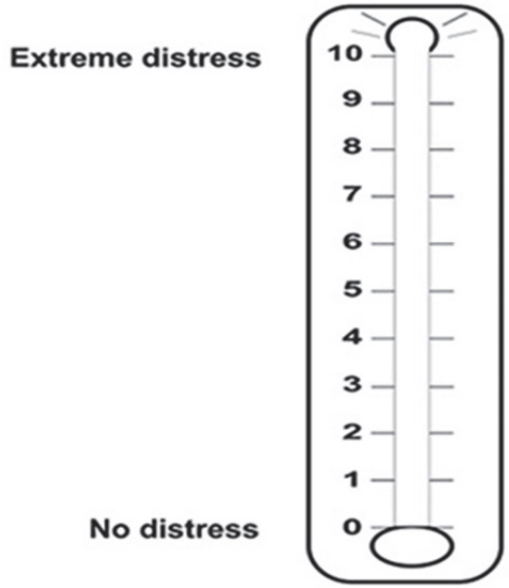
1. Have you had a total hysterectomy with BSO (bilateral salpingo-oophorectomy)? _____ Date: _____
2. Have you had your entire uterus removed? _____ Date: _____
3. Did you have just your left ovary removed? _____ Date: _____
4. Did you have just your right ovary removed? _____ Date: _____
5. Other ovary surgery? _____
6. Other uterine surgery? _____

PROVIDENCE
Alaska
Medical Center

At the Providence Cancer Center we strive to provide care for each person as a whole being: body, mind and spirit. Recognizing that cancer can impact your life in many ways, especially during treatment, as part of today's visit we will assess your level of stress and discuss resources in the Cancer Center and community that can support you.

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

Patient Name: _____

DOB: _____

Staff Signature: Reviewed by _____ Date _____