WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
PATIENT DEMOGRAPHICS

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):
☐ Same as the home address

| Phone:<br>Is this a cell phone? ☐ Yes ☐ No | Alternate Phone:<br>Is this a cell phone? ☐ Yes ☐No |
|---|---|
| Email Address: | Preferred Contact Method:<br>☐ Phone ☐ Alternate Phone ☐ Email ☐ Patient Portal |

## Patient Demographics

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Choose not to disclose

| Preferred Pronouns:<br>☐ She, Her, Hers<br>☐ He, Him, His<br>☐ They, them, theirs<br>☐ Other, please describe<br>_____<br>☐ Choose not to disclose | Gender Identity:<br>☐ Female<br>☐ Male<br>☐ Transgender Male (FTM)<br>☐ Transgender Female (MTF)<br>☐ Genderqueer/Non-binary<br>☐ Other, please describe<br>_____<br>☐ Choose not to disclose | Sexual Orientation:<br>☐ Straight or Heterosexual<br>☐ Lesbian, Gay, Homosexual<br>☐ Bisexual<br>☐ Other, please describe<br>_____<br>☐ Unknown<br>☐ Choose not to disclose | Sex (Assigned at Birth):<br>☐ Female<br>☐ Male<br>☐ Unknown |
|---|---|---|---|

| Race:<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ White<br>☐ Other Race, please specify _____<br>☐ Choose not to disclose | Ethnicity:<br>☐ Hispanic or Latino<br>☐ Not Hispanic or Latino<br>☐ Unknown<br>☐ Other, please specify _____<br>☐ Choose not to disclose |
|---|---|

| Preferred Language: | Preferred Language for Written Documents: | Do you need a medical interpreter at appointments at no cost?<br>☐ Yes, specify language _____<br>☐ No |
|---|---|---|
| Occupation and Employer: | Employment Status: ☐ Employed ☐ Unemployed<br>☐ Retired ☐Student (Full) ☐ Student (Part)<br>☐ Choose not to disclose | |

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:**

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 WVCI, and I hereby assign to WVCI all assignable rights to payment for services rendered by WVCI, 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 WVCI, other providers, and insurers for treatment, payment and health care operations purposes.

I understand that in order for 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 WVCI may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize WVCI to obtain my prescription history.

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:<br><br>(for patients 17 years of age or younger, parent or guardian MUST sign) | Relationship to Patient: |
|---|---|
| Printed Name: | Date: |

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

WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
ONCOLOGY ASSOCIATES OF OREGON
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Willamette Valley Cancer Institute and Research Center (WVCI) has a responsibility to protect the privacy of your health care information. WVCI 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 WVCI at 541-683-5001 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 Willamette Valley Cancer Institute and Research Center.

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 | |
|---|---|
| *If acknowledgment was not obtained, please state the reason:* | |
| | |
| | |
| PRINTED WVCI EMPLOYEE NAME | SIGNATURE OF WVCI EMPLOYEE |

At **Willamette Valley Cancer Institute and Research Center (WVCI)**, we are committed to alleviating the financial burden on our patients. Our dedicated team will diligently work to review and enroll eligible patients in various patient assistance programs. These programs are designed to provide financial relief by offering free or reduced-cost treatments. We strive to ensure that our patients have access to the necessary resources and support, allowing them to focus on their health and well-being without the added stress of financial concerns. Rest assured; we will explore all available options to assist you in managing your healthcare expenses.

## AUTHORIZATION AND ATTESTATION FOR FINANCIAL ASSISTANCE

I understand that **WVCI** and its affiliates (including *The US Oncology Network and Annexus Health*) are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment. In order for **WVCI** and its affiliates to provide me with financial assistance, I understand that they will need to obtain, review, use, and/or disclose my personal health information (PHI), information relating to my medical condition, and information that I otherwise provide to **WVCI** and its affiliates, including my name, address, and other personal identifying information.

I authorize **WVCI** to use my personal health information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I also authorize my physician, pharmacy, insurance companies, and health plan(s) to disclose my personal health information to **WVCI** and its affiliates as necessary to complete applications on my behalf or to verify information on my application.

I understand that my physician and **WVCI** do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers (“Programs”) and is contingent upon the eligibility criteria set forth by the program. I understand that the charitable foundations and product manufacturers (“Programs”) may perform a “soft credit check” to obtain confirmation of household reported income.

By authorizing **WVCI** to submit my application, I attest that I understand and agree to the below statements.

- I understand **WVCI** and/or their affiliates may contact me to obtain any additional information needed to complete an application.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I may provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- I understand that all assistance from Programs is subject to availability of funds at the time funds are requested and that this Authorization is not a guarantee that I will receive or obtain any financial assistance.
- I agree that all information I provide to **WVCI** and applicable Programs, to the best of my knowledge, is true, accurate, and complete, and I will notify **WVCI** and any relevant Program of any changes to the information I provide.
- I agree and authorize **WVCI** and the Assistance Program Sponsor(s) to disclose, obtain, and discuss my medical, treatment, therapy, financial, and other personal information relating to my application with my providers, pharmacy, insurance company, and other organizations working on my behalf to obtain eligible treatment.
- I understand that my protected health information disclosed to **WVCI**, to a Program, or under an applicable application for my financial assistance may be re-disclosed by recipients of my health

Patient Initials_____

information for the purposes described in this Authorization and may no longer be protected by privacy laws, such as HIPAA.

- I understand that if I have applied for assistance elsewhere, I must disclose this to any other Foundation or Patient Assistance Program that approves me for funds or drug product.
- I understand that there is no fee or charge for this support service.
- I understand that the Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me. The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat or cover only certain conditions. Should additional assistance be needed for continuity of treatment, I understand that **WVCI** will complete and submit applications to secondary Programs or submit renewal applications on my behalf.
- I understand and acknowledge that if I do not sign or provide this Authorization, my physician or **WVCI** cannot withhold or condition my healthcare or treatment based on my decision to not sign or provide this Authorization.
- I understand that this authorization is valid for 12 months. I (or my legally authorized representative) may cancel this Authorization at any time by mailing a written request for such cancellation to **WVCI**. However, I understand that any cancellation will not apply to any information already used or disclosed pursuant to this Authorization. I understand that I may request a copy of this Authorization once it has been signed.
- If applicable, I consent to the use of electronic signatures to complete, sign, and deliver this Authorization and agree that my electronic signature is as valid as if I signed the document in writing.

Patient Name (*print*): _____

Patient DOB: _____

**PLEASE SIGN ONE OF THE SECTIONS BELOW**

**I agree and certify that I have read, understood, and will abide by the above attestation and authorize Willamette Valley Cancer Institute and Research Center to proceed with applying for assistance on my behalf.**

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____

**I choose to decline and/or retract my authorization for Willamette Valley Cancer Institute and Research Center and the above listed affiliates to proceed with applying for assistance on my behalf.**

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____

# 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 | ✓ | 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 | Emergency Contact? |
|---|---|---|---|
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |

## 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***

**Medical History Form**

**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)

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

# Review of Symptoms

**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

**Check this box if you do ***NOT*** have any symptoms listed:**

☐I do **not** have any symptoms.

Reviewed/Approved, OCM Quality Committee, May 2017, updated 2/12/2026

# Ambient and Remote Scribe Technology

Your provider uses a secure and HIPAA-compliant technology that may use ambient and remote scribe tools. These tools will create your electronic medical records in real-time or non-real time and assist your provider throughout your visit. The audio stream or recording is stored securely in accordance with HIPAA guidelines and used for better medical care delivery, improved medical documentation, and quality assurance. The audio stream or recording will not be retained on a permanent basis. The audio stream or recording will not be used outside routine treatment and operations.

I have been informed that it is my choice if I want to use ambient and remote scribe technologies in my visit with my provider. I also realize that by signing this form, I give my consent to allow the provider to use this technology in all my future visits. I have had all my questions answered by the provider or staff member.

If at any time I decide not to allow this technology, I am to let the staff or provider know, and the provider will not use it.

I understand the above, and consent to the use of ambient and remote scribe technology in my appointments. This consent is valid from the date I sign, for all future visits. At any point in time, it is my right to decline the use of ambient and remote scribe technology.

_____ _____

Patient name (please print) Date of Birth

_____ _____

Signature of patient or legally authorized representative Date