Cascade Cancer Care

Confidential Health History Form

Name First _____ Middle _____Last _____
Preferred name: _____Date of Birth: _____ Gender: _____
Email: _____Preferred phone is: home_____ work_____cell____
Home phone: _____Work phone: _____Cell phone: _____
Mailing Address: _____
Credit Card Billing Address, if different_____
Health care power of attorney name and phone:_____
Emergency Contact name: _____ phone: _____
Caregivers authorized to discuss medical information with our office:
Name, phone, relationship: _____
Name, phone, relationship: _____
Do you have an advanced directive or POLST? No____Yes, I will provide a copy.___
If Insured Person Is Someone Else, Complete Next Section With Insured's Information.
Insured Person's Full Name_____
Relationship to Patient:_____Date of Birth_____ Gender_____
Physician Team: List full name. If not in Central Oregon, also list practice name and city.
Referred by: _____
Medical Oncology: _____
Primary Care Physician: _____
Radiation Oncology: _____
Surgical Oncology: _____
Palliative Care or Hospice: _____
Other: _____
Preferred Pharmacy (Name, Street, City):_____
What Are Your Goals For Integrative Cancer Treatment? How Can I Help You?

Cancer Care History

Cancer diagnosis:

Current or planned treatment:

Current health issues related to previous cancer treatment:

Treatments received for these side effects. Note if helpful:

Other current medical diagnoses -- beyond those already listed above

Do you know of anything that may have contributed to the development of the cancer?

Treatment Options

Natural therapies that I am most interested in receiving or that work well for me:

Needs that affect our treatment options? e.g difficulty swallowing pills, taste or texture sensitivity, budget, sensitive constitution, no alcohol, need help streamlining supplements

I can commit to taking medications or supplements:
Twice daily_____ Three times daily_____ Whatever will be most effective_____
Many integrative therapies are not covered by insurance. For these therapies, my monthly budget is:
$0-50___ $50-125____ $125-200___Whatever will be most effective_____Let me think about it. _____
My commitment to address underlying causes of illness that relate to lifestyle is (0-100%): _____

What obstacles do you foresee in pursuing a healthy lifestyle and integrative treatment plan?:

What do you regularly do that supports your health? (please list)

What do you regularly do that may decrease your health? (please list)

Social History and Health Habits

Occupation or Former Occupation:_____ Employer:_____
Work status: Employed____Self-Employed___Unemployed____Student____Disabled___Retired___
Hours Worked Per Week:_____ Is There Anything In Your Home or Work Environment That Affects Your Health?:_____ Religion:_____
Relationship status: Single____Married___Partnered____Separated____Divorced____Widowed___
Children? No____Yes ____ Ages and genders_____
Do you use **tobacco**? Currently_____Past (Quit Date_____) Never_____
Form and frequency:_____
Exercise type, duration, and frequency?_____
Hobbies, or what you love to do:_____
Do you have any **dietary restrictions**? No____ Yes, specify:_____
Three **healthiest foods** you eat regularly?_____
Three **unhealthiest foods** you eat regularly?_____
How many **fruit and vegetable** servings do you eat daily (piece or 1/2 cup)?:_____
Notable **toxic exposures**? No____Yes, list:_____

Do you: (check all that apply) Have significant home or work stress?_____Have enough social support?_____ Have a supportive relationship?____Drink alcohol?_____Drink alcohol more than 1 drink daily?_____Use TV, videos, or computer within 1 hour of bedtime?_____Spend time outside?_____ Enjoy work/school?____Drink less than 64 oz water daily?___ Drink soda?____

Cancer Family Medical History — Genetic Family Only. For each condition, list what and who.

Relation, Age at Diagnosis, and Location/Type of Cancer:_____
Relation, Age at Diagnosis, and Location/Type of Cancer:_____
Relation, Age at Diagnosis, and Location/Type of Cancer:_____
Relation, Age at Diagnosis, and Location/Type of Cancer:_____
Relation, Age at Diagnosis, and Location/Type of Cancer:_____
Other illnesses common in genetic family:_____

Past Medical History: Surgery, Serious Illness, Or Accidents Not Yet Listed Above

Event, date:_____
Event, date:_____
Event, date:_____
Event, date:_____
Event, date:_____
Event, date:_____

Women With Breast or Gynecologic Cancers Only:

Number of Pregnancies:_____Number of Live Births:_____ Age at first menstrual period:_____
Sex Hormone Replacement Used? No___Yes, Type, Duration_____
Menopause Age: _____Natural, Surgical, or Drug-Induced?:_____ If hysterectomy, ovaries removed? No___Yes __ ; if no, was menopause later confirmed with hormone bloodwork? No___Yes __

Women With Breast Cancer Only:

Age at First Childbirth_____Total Months Breastfeeding_____

Activity: Circle the number that best describes what you can do.

0: Fully active, no restrictions
1: No strenuous activity. Can walk or do light work
2: Can care for self but not work. Up >50% waking hours
3: Limited self care. Confined to bed or chair >50% waking hours
4: Fully disabled. Cannot do self care. Confined to bed or chair.

Current Symptoms Circle below. Fill in blanks for other symptoms.

General: fevers, night sweats, unintended weight loss/gain, pain, fatigue, trouble falling asleep, trouble staying asleep, sleep less than 7 hours nightly, wake unrefreshed_____

Head/Neck/Ears/Eyes/Nose: mouth sores, hoarse voice, taste changes, hearing loss, ringing in ears, vision change, bloody nose, nasal congestion, hay fever_____

Digestion: nausea,diarrhea, constipation, abdominal pain, blood in stools, swallowing problems, heartburn/reflux, cirrhosis, eating difficulties, _____

Cardiovascular: chest pain, irregular heartbeat, heart race/flutter, murmur, legs swell,_____

Respiratory: short of breath, cough, coughing blood, snoring, asthma_____

Infectious: frequent infections, current contagious infection, recent antibiotics, HIV risk/exposure, TB exposure, hepatitis exposure,_____

Endocrine: hot flashes, thyroid problems, steroids recently,_____

Bone/Joints: osteopenia, osteoporosis, bone pain, muscle pain, back pain, arthritis,_____

Blood: clots, DVT or PE, abnormal bleeding, lymph nodes swollen, anemia, blood disorder,_____

Urinary: burning/pain, bloody urine, kidney stones, frequent at night, dribbling, incontinence, ____

Neurologic: cognitive dysfunction (“chemo brain”),headaches, numbness/tingling, weakness, memory loss, seizure, _____

Skin: nail texture change, eczema, hives/rash, hand/foot syndrome, dry skin, _____

Immune: ulcerative colitis, Crohn's, rheumatoid arthritis, antibiotics recently_____

Male: erectile dysfunction, prostate enlarged, libido low,_____

Female: pregnant currently, breast lumps, breast rash, vaginal bleeding/spotting, nipple discharge, nipple pain, libido low, vagina dry, intercourse painful, vaginal infection, _____

Medical Devices: port, pacemaker, catheter, urostomy, colostomy, G-tube, J-tube, _____

Allergies

Drug Allergy: None___List_____

Food Allergy or Intolerance None____List_____

Environmental Allergy: (mold, dust, etc) None____List_____

Current Medications, Prescription or Over the Counter.

Medication Name	Dose	Frequency	Reason for Prescription	Prescribing Physician	Start Date (mo/yr)

Current Supplements.

Name	Brand	Dose	Frequency	Reason	Prescriber	Start Date (mo/yr)

Patient Signature

The information is correct to the best of my knowledge. I will contact the clinic promptly if my medical history changes. I am aware that this information will become part of my confidential medical record.

Name:_____Signature:_____Date:_____

Cascade Cancer Care
Dr. Katherine Neubauer, ND, FABNO
25 NW Louisiana Ave, Suite 100, Bend OR 97703
Tel: 541.323.3833, Fax: 541.550.3662
Email: office@cascadecancercare.com, Web: cascadecancercare.com

OFFICE USE ONLY

DATE: _____

I hereby authorize release of records/medical information to:

Dr. Katherine Neubauer, ND, FABNO, Fax: 541.550.3662

25 NW Louisiana Ave, Suite 100, Bend OR 97703

Records to include:

LABS __ IMAGING REPORTS: __ CHART NOTES: ___ OTHER:_____

Patient authorizes records/medical information to be obtained by or released to:

PHYSICIAN/INDIVIDUAL: _____

ADDRESS: _____

PHONE: _____ FAX: _____

RECORDS DATE RANGE: _____

Patient authorizes Dr. Neubauer & Cascade Cancer Care staff to discuss or coordinate care or services with the above health care provider/clinic or individual.

PATIENT TO COMPLETE

PATIENT NAME:

_____

DATE OF BIRTH:

_____

ADDRESS:

_____

CITY,STATE,ZIP:

_____

SIGNATURE:

_____

WELCOME TO CASCADE CANCER CARE

Thank you for choosing Cascade Cancer Care for your health care needs. We seek to provide you with the most powerful and supportive combination of care available by using the skills of an integrative physician to draw upon both the latest treatments developed by modern science and the wisdom of integrative medicine.

You play an integral role in your own health and in the management of your care. As a new patient, we want to inform you of how we will protect your private information, make you aware of the responsibilities you are taking on, and ask for your consent to treat you. Please read the following forms carefully and make you sure you understand them before signing. We have also included a description of our general policies so you know how we will work with you.

We look forward to addressing your health needs. We encourage your questions and participation in all aspects of your health care.

INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE

In this document, "I" and "me" refers to the patient whose signature is below:

I hereby authorize and request evaluation, diagnosis, and treatment services from the physicians ("Physicians") of Cascade Cancer Care ("CCC"). I understand that the services may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, strain-counterstrain, naturopathic/osseous manipulation of the spine and extremities, and light therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular vitamin injections)
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over-the-counter and prescription medications

I recognize that I have a right to be informed about my condition and recommended care. This Consent is to help me become better informed about potential treatments so I may give, or withhold, my consent after discussing my condition. I acknowledge that the information

provided by this Consent is necessarily general, and I shall always have the right and am encouraged to discuss proposed treatments in further detail with my Physicians. I always have the right to discuss the potential benefits, risks, side effects, or hazards of any treatment; to inquire about the likelihood of success of any treatment; and to discuss alternative treatment options or the potential consequences if treatment or advice is not followed or nothing is done.

I understand and I am informed that in the practice of naturopathic medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

Potential risks: allergic reactions; side effects; adverse interactions with other therapies; inconvenience of lifestyle changes; or injury or infection from injections, venipuncture, medical devices, or other procedures. CCC follows universal precautions for infection prevention. These precautions greatly reduce, but do not fully eliminate, the risk of a healthcare acquired infection.

Potential benefits: restore health and the body's maximal functional capacity; relieve pain or symptoms of disease; injury or disease recovery; and prevention of disease or its progression.
Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

Notice to Oncology Patients

I understand that Dr. Neubauer is a naturopathic physician who is board certified in naturopathic oncology. I understand that she is not a board certified medical oncologist (BCMO). I understand that Dr. Neubauer is focused on integrative oncology and does not provide primary care. As such, none of the Physicians of Cascade Cancer Care are trained nor qualified to manage the overall care of a person with cancer. Instead, I should engage my own board certified oncologist (BCMO) and primary care physician (PCP) for such care, and will request a referral if needed.

I understand it is important to make my BCMO/PCP aware of the care and advice I receive from Cascade Cancer Care. CCC may share my records to coordinate care unless I advise otherwise.

I understand the importance of maintaining a current health record. I will promptly notify CCC of any changes in my personal or family medical history, allergies, medications or supplements.

I understand my Physicians may suggest changes to the BCMO's cancer treatment plan, and that such changes should be carried out either by or in conjunction with my BCMO. Treatment suggestions provided by the Physicians at CCC are not necessarily intended to replace any treatments prescribed by the BCMO.

Treatment suggestions provided by the Physicians are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that the primary goal of naturopathic oncology care is the enhancement of quality of life and that care, treatment, and advice from the Physicians at CCC with reference to my cancer care are not necessarily offered as a cure for my cancer.

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For All Patients

I understand that Cascade Cancer Care occasionally offers preceptorships to medical students and resident physicians who may observe or participate my care. I have the right to decline their presence at any time. I understand that medical students, residents, and office staff are subject to, and will abide by, CCC's privacy policies.

I acknowledge that I have been provided ample opportunity to read and understand this document. I have had any questions satisfactorily answered. I am legally competent to sign this document. If I am signing on behalf of the patient I warrant that I am authorized to act as the patient's legal guardian or health care attorney in fact. If I provide a digital signature, I attest that I am signing the document via a secure patient portal, that I am the person signing, and that I intend for my signature to hold the same validity as a paper signature.

I understand the information regarding the potential risks and benefits of treatment. With this knowledge, I voluntarily consent to treatment, acknowledging that no expressed or implied guarantees have been made to me by CCC, the Physicians, or any affiliate physician or staff regarding cure or improvement of my condition. I also realize that my practitioner(s) cannot anticipate and explain every possible risk or complication, and I wish to rely on the practitioner to exercise judgment during any of the above procedures and in recommending any other treatments for my condition(s). I am free to ask for further information at any time.

I understand the above and give my consent to the evaluation and treatment, including the entire course of treatments for my present condition and any future conditions for which I seek treatment. I also understand that I am free to withdraw my consent and to discontinue participation in these medical services at any time.

_____ _____

Patient or Guardian Signature Date

_____

Printed Name of Signing Patient or Guardian

_____

Name of Patient, if Different

OFFICE POLICIES AND FINANCIAL RESPONSIBILITY AGREEMENT

Office Hours: The office is open Monday, Thursday, and Friday, excepting holidays. Consults are by appointment. After hours messages are returned the next business day.

Appointment Scheduling & Missed Appointment Fee: The staff at CCC may leave you a message containing appointment information. To facilitate communication, we subscribe all patients to the following services: patient portal access, email and text reminders for appointments and notice of posts to the patient portal, and an email newsletter. You may request to be unsubscribed from any of these services, and can request we contact you in a specific way.

You will be charged a $50.00 fee for missed appointments, for cancellations with less than 24 hours notice, or for failing to arrive within 10 minutes of your scheduled time. Exceptions will be made only in the case of a verified emergency, severe inclement weather, or at your doctor's discretion. 3 missed or late cancelled appointments may result in dismissal from care.

Patient Portal Secure healthcare messaging is available through the patient portal, accessible through our website. For non-urgent questions after hours, please use the patient portal messaging service. Simple questions, such as a dose clarification or updating your allergy list, are answered without a fee. We will reply to complex questions at your next appointment. Please use the patient portal and not email for all healthcare communication to protect the confidentiality of your health information.

After Hours Service: Although CCC physicians do not function as your primary care physician or as an emergency medical service, they (or a covering physician) are available 24 hours/day for urgent health concerns that are specific to your integrative oncology care and that cannot wait until the next business day. To contact the after hours service, call the office and follow the instructions on our voicemail. Urgent messages will receive a same-day reply and are subject to a $25 convenience fee. The fee is waived for urgent messages relating to either complications of treatments we have prescribed or messages from collaborating treating physicians. Please be respectful of family time by using the after hours service only when truly needed, and preferably between the hours of 9 am – 9 pm. Abuse of the after hours service may lead to patient dismissal.

Supplements: Dietary supplements recommended by CCC are typically not covered by health insurance, though you may be able to apply funds from your Health Savings Account (HSA). You may purchase supplements from numerous sources. You physician will recommend specific products that are selected for their purity, potency, and correct dose and type. As a patient convenience and to ensure quality control, patients can order these products through us. **You assume all risk for supplements you choose to purchase from sources not recommended by CCC, as we cannot assure the quality or handling of these products.** Supplements purchased from us may be returned if they are unopened and have at least 1 month left before their expiration date. Compounded, special order, open, and heat sensitive products are not returnable.

Medical Records Requests: We will provide you one free copy of your medical records in any one year period; a reasonable processing fee will be charged for additional requests. All records requests require a signed request of records form.

Payment & Financial Responsibility Agreement

It is ultimately your responsibility to pay for all services and products you receive through CCC. All fees are due at the time of service and are payable by cash, check, or major credit card. Account balances must be paid before further services or goods can be provided. You may put a credit or debit card on file with us to ensure prompt payment; by doing so, you are agreeing that we can charge it when fees are due.

Prompt Payment Bonus: You will receive a 25% discount on consultation fees if you pay them directly at the time of service.

Insurance Billing: If we are able to verify insurance coverage prior to your appointment we will bill your insurer directly. Our website lists participating insurers. Fees for co-payment, co-insurance, non-covered services, and services exceeding your benefits limit are due at the time of service. Fees billed to your insurer that are denied are due after your insurer processes the claim.

Returned Checks and Late Penalty Interest: Checks returned for insufficient funds will result in a $30.00 fee in addition to the amount due. Any outstanding balance on your account is due in full within 30 days of billing. After 30 days, any outstanding balance will accrue interest at 9% per annum until paid. After 90 days your bill will be forwarded to an outside collection agency. You are responsible for any fees or costs incurred in collection efforts.

Insurance: Insurance coverage can vary greatly for naturopathic services. It is ultimately your responsibility to know the benefits, limitations, and other details of your insurance. Health insurance is a contract between you and your insurer and does not limit your financial responsibility to pay for our services. It is also your responsibility to keep your contact and insurance information up to date with our office. Any guarantor of your policy is subject to the same financial policies as the patient. Some third-party payers may require that your medical information, including copies of treatment notes, be submitted along with requests for payment.

Insurance -- Covered services: For each covered service and/or procedure provided, we will only charge your insurance the "allowable amount", as defined uniquely by each individual carrier, and will not bill you for the difference (excluding co-payments, co-insurance, and any deductible as defined by your individual health plan).

Insurance -- Non-covered services: Some of the testing, services, procedures and therapeutic products recommended by CCC may not be covered by your insurance plan. Or your insurance company may refuse coverage or pay only a portion or percentage of fees. As a courtesy, CCC will try to identify possible non-covered services in advance of treatment. You are responsible for any and all allowable fees not covered by your insurance plan.

Non-covered services are those services, visits, procedures, diagnostic codes, etc., that are not

covered by your health insurance policy. It is your responsibility to verify which services are covered. You are fully responsible for, and we will bill you directly for, any denied charges or non-covered services. Non-covered services may include, but are not exclusive to, the following:

- Naturopathic care services, if your insurance company restricts covered providers. You may, however, have the right to dispute this under the provider non-discrimination clause of the Affordable Care Act.
- Wellness visits
- Counseling
- Missed, late cancel, or late arrival appointment fees. After hours service fees.
- Extended consultation time
- Written reports and forms
- Medical equipment
- Dietary supplements
- Treatments that are considered 'investigational,' 'experimental,' 'not medically necessary,' not approved by the Food and Drug Administration (FDA), or that are used to assess or support normal physiology rather than to treat disease. These may include, but are not limited to: low level laser therapy, nutritional or botanical injection therapies, "off-label" drugs, functional medicine services, and functional lab tests.
- Visits to your home, nursing home or assisted living facility, or hospital room
- Telemedicine, including phone consults and after hours consult convenience fee.
- Fees for returned checks, overdue balances, or collections

Insurance -- Referral Release: By signing below, I authorize CCC to provide health care product or service referrals based on my health care needs and requests, rather than on the basis of insurance network membership. I take responsibility for verifying insurance network status of any referrals, and will hold CCC harmless for any out-of-network costs related to these referrals.

Insurance -- Assignment of Benefits: I authorize Cascade Cancer Care to release all medical information necessary to secure payment of benefits from third- party payers that provide. I authorize the use of this signature on all related submissions. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Notice of Privacy Policy: By signing below, I acknowledge that I have received and reviewed the Cascade Cancer Care Notice of Privacy Policy, and that I am aware I can request another copy for my own records. The Privacy Policy is available in our office and on our website.

By signing below, I agree to this Office Policies and Financial Responsibility Agreement and acknowledge that I am ultimately responsible for the payment of all fees relating to my treatment at CCC.

_____	_____	_____
Patient or Guardian Signature	Printed Name	Date

_____
Patient Name, If Guardian Signs Above