ROCKY MOUNTAIN ONCOLOGY
ONE TEAM. ONE FOCUS. LIFE.

WELCOME TO ROCKY MOUNTAIN ONCOLOGY

LOCATIONS:

CASPER, WY
6501 E. 2nd Street
Casper, WY 82609
Ph: 307-235-5433
Fax: 307-233-4700

LANDER, WY
15 Shrine Club Road
Lander, WY 82520
Ph: 307-332-0324
Fax: 307-332-0382

DOUGLAS MEDICAL CLINIC
700 East Center
Douglas, WY 82633

Thank you for trusting us with your care. At Rocky Mountain Oncology, we believe cancer treatment requires medical intervention, however we also believe that a strong will and a solid support system play a vital role in the healing process. That is why our expert team of highly-skilled cancer care professionals work together closely with our patients and their loved ones throughout treatment and recovery. It is this compassionate approach, combined with our state-of-the-art facilities, comfortable environment and commitment to utilizing the most advanced treatment techniques available that help make Rocky Mountain Oncology a premier oncology center.

For your first visit, please fully complete and sign all forms included in your packet. You will need to present these forms to the front desk upon your arrival. If you are unable to complete these forms before your first appointment, please arrive 30 minutes early and we will assist you. If you need to reschedule or cancel your appointment, please call at least 24 hours before your scheduled visit.

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you with the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available.

We accept most insurance carriers and our staff will work with you before you come for your initial appointment to ensure that you have the coverage you will need. If you have a managed care plan that requires a referral from your primary care physician, please ensure that you have obtained that referral as it is the patient's responsibility to do so. Referrals occasionally have limits on the number of visits which patients may be allowed and/or an expiration date. Please monitor this information and obtain updated referrals as required. Co-payments, deductibles and non-insurance covered medical services are due at the time of the service.

WE ASK THAT PATIENTS ALWAYS:

- Bring insurance cards to each visit. If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure to bring all of your cards.
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over the-counter medications currently being taken including vitamins, herbs, aspirin, Tylenol, etc. Some patients find it more convenient to bring the medication bottles to the appointment.
- Allow a 72-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- Consider the compromised immune systems of other patients and refrain from bringing children to your appointments. If you are feeling ill, please call us prior to your appointment so we can provide guidance.
- Write down any questions or concerns that arise to discuss with the physician.

Once a patient has made an appointment, all facets of our services–from the latest research findings to the most advanced technology–will be utilized in providing the highest level of quality medical care. Please complete the patient registration forms BEFORE your appointment.

Again, we welcome you and say thank you for choosing Rocky Mountain Oncology. For further information, please visit our website at www.rockymountainoncology.com. Should you need additional assistance, please call, **(307) 332-0324**.

MRN:

ROCKY MOUNTAIN ONCOLOGY
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PATIENT REGISTRATION

PLEASE PRINT CLEARLY Today's Date: _____

Patient Name: _____

DOB: ____ /____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ May we email you? ☐ Yes ☐ No

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American
☐ Asian/Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ Work Phone: (_____) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home
☐ Winter Resident ☐ Year Round Resident

Are you currently receiving home health? ☐ Yes ☐ No

Children: ☐ Yes ☐ No If yes, how many? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

List Any Other Physician: _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Patient Initials: _____

MRN:

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PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: (___) _____

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No _____

Relation to You: _____

Living Will for Healthcare: ☐ Yes* ☐ No *Please provide a copy for our records

PRIMARY

Insurance Carrier: _____

Name of Primary Policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes, please provide information below)

Prescription Coverage: _____

SECONDARY

Insurance Carrier: _____

Name of Primary Policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes, please provide information below)

Prescription Coverage: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials: _____

Witness Name: _____ Witness Relationship: _____

Witness Signature: _____

MRN:

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MEDICAL HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name: _____

Reason For This Visit: _____

SURGICAL HISTORY

Procedure	Date Performed	By Whom

Do you have an implanted device, such as a pacemaker? ☐ Yes ☐ No

If yes, please provide a copy of your device card for our records.

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Have you had radiation or chemotherapy treatment in the past? ☐ Yes ☐ No

ALLERGIES AND SENSITIVITIES:

(List Allergies you have and how each affects you.)

☐ No known allergies Allergy ☐ No known drug allergies

Allergy	Reaction

Have you ever had a reaction to anesthetic? ☐ Yes ☐ No

CURRENT MEDICATIONS:

(ATTACH MEDICATION LIST IF NEEDED)

Name	Strength / Frequency	Prescriber

ALL NON-PRESCRIPTION MEDICATION INCLUDING VITAMINS AND HERBS:

Pharmacy _____ Address _____ Phone # _____

Patient Initials: _____

MRN:

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MEDICAL HISTORY FORM

FAMILY MEDICAL HISTORY:

Indicate any family members with breast, ovarian, pancreatic, prostate, melanoma, colon, kidney or uterine cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sisters/Brothers:	_____	_____	_____
Children:	_____	_____	_____
Aunts/Uncles:	_____	_____	_____
Maternal Grandparents:	_____	_____	_____
Paternal Grandparents:	_____	_____	_____

SOCIAL HISTORY:

Work Hazards:
Any occupational hazards (like noise or chemical exposures)? ☐ Yes ☐ No If yes, what:_____

Tobacco Use: (Present and/or past)
☐ Never smoked
☐ Quit smoking When?_____ How many years did you smoke?____ yr(s) Age started:_____
How many packs?_____/day
☐ Currently smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes
How many packs?_____/day How many years?_____
☐ Chewing tobacco ☐ Current ☐ Past How long?_____

Alcohol Use: (Present and/or past)
☐ Non-drinker
☐ Beer: Number of bottles _____ per ☐ Day ☐ Week ☐ Month
☐ Wine: Number of bottles _____ per ☐ Day ☐ Week ☐ Month
☐ Liquor: Number of bottles _____ per ☐ Day ☐ Week ☐ Month

NUTRITIONAL HISTORY:

Has there been a change in your appetite in the past 6 months? ☐ Yes ☐ No
How is your appetite? ☐ Appetite Good ☐ Appetite Fair ☐ Appetite Poor
Have you gained or lost weight in 1 month without wanting to? ☐ Yes ☐ No
If yes, how much gain or loss? _____
Are you happy with your weight? ☐ Yes ☐ No
If not, are you on a diet and exercise program? ☐ Yes ☐ No
For women: Are you taking any extra calcium? ☐ Yes ☐ No

MRN:

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MEDICAL HISTORY FORM

REVIEW OF SYSTEMS:

(Please check any past or current symptoms you have.)

General:
☐ Good Health
☐ Excessive Fatigue
☐ Weight Loss
☐ Obesity
☐ Unexplained Fevers
☐ Chills
☐ Weakness

Immune System:
☐ Frequent Colds
☐ Outdoor Allergies
☐ Serious Infections

Respiratory:
☐ Pneumonia
☐ Tuberculosis
☐ Emphysema
☐ Asthma
☐ Chronic Cough
☐ Productive Cough
☐ Coughing Up Blood
☐ Short of Breath
☐ Wheezing

Head and Neck:
☐ Cataracts
☐ Glaucoma
☐ Sinus Problems
☐ Sore Throat

HEENT:
☐ Blurred Vision
☐ Double Vision
☐ Glaucoma
☐ Sensitivity to Light
☐ Dry Eyes
☐ Excessive Tearing
☐ Hearing Loss
☐ Ringing in Ears
☐ Mouth Sores
☐ Dry Mouth
☐ Altered Taste
☐ Sinus Tenderness
☐ Hoarseness
☐ Jaundice

Endocrine:
☐ Diabetes
☐ Thyroid Disorder
☐ Hot Flashes
☐ Night Sweats
☐ Hormone Replacement

Hematological:
☐ Anemia
☐ Swollen Lymph Nodes
☐ Blood Clots
☐ Platelet Problems
☐ Surgical Bleeding
☐ Abnormal Bruising
☐ Bleeding Gums
☐ Nose Bleeds
☐ Blood Transfusions
☐ Bleeding Disorder
☐ HIV/AIDS

Breast:
☐ Abnormal Masses
☐ Nipple Discharge
☐ Nipple Inversion
☐ Pain
☐ Skin Changes
☐ Axillary Mass

Cardiovascular:
☐ Chest Pain
☐ Palpitations
☐ Heart Attacks
☐ Hypertension
☐ Heart Failure / Heart Disease
☐ Leg / Feet Swelling
☐ Heart Murmur
☐ Rhythm Problems
☐ High Cholesterol
☐ High Blood Pressure
☐ Diabetes: Type 1 / Type 2

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Vomiting
☐ Stomach Ulcers
☐ Rectal Bleeding
☐ Gallbladder Problems
☐ Hepatitis
☐ Reflux Disease
☐ Black Stools
☐ Bowel Changes
☐ Abdominal Pain
☐ Hemorrhoids
☐ Nausea
☐ Kidney Stones
☐ Difficulty Swallowing
☐ Heartburn
☐ UTI
☐ Cirrhosis of Liver

Genitourinary:
☐ Urinary Loss
☐ Frequent Urination
☐ Pain with Urination
☐ Blood in Urine
☐ Bladder Problems
☐ Incontinence
☐ Hesitancy
☐ Erectile Problems

Musculoskeletal:
☐ Arthritis
☐ Bone Pain
☐ Gout
☐ Osteoporosis
☐ Muscle Pain
☐ Joint Pain
☐ Joint Swelling
☐ Limited Range of Motion
☐ Back pain

Neurological:
☐ Headache / Migraine
☐ Focal Weakness
☐ Paralysis
☐ Neuropathy
☐ Speech Impairment
☐ Tremor
☐ Altered Consciousness
☐ Balance / Dizziness
☐ Stroke / TIA
☐ Seizure
☐ Fainting Spells
☐ Memory Loss
☐ Confusion

Psychiatric:
☐ Sleep Trouble
☐ Depression
☐ Anxiety
☐ Appetite Changes
☐ Suicidal Thoughts
☐ Panic Disorder

Integumentary (Skin):
☐ Rash
☐ Itching
☐ Skin Lesions

Gynecologic:
Heavy Periods: ☐ Y ☐ N
Age Period Started: _____
Date of Last Period: _____
# of Pregnancies: _____
Abortions / Miscarriages?
☐ Y ☐ N
Breastfeed: ☐ Y ☐ N
Date of Last Pap: _____
Date of Last Mammogram:
_____

PAIN SCALE

Are you in pain? ☐ Yes ☐ No *(If yes, please indicate on a scale of 1-10 (0= no pain, 10= worst pain)*

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

OTHER ILLNESS OR MEDICAL PROBLEMS:

(Please list current and past medical problems that you have been treated for AND the physician who treated you.)

_____ Dr. _____

_____ Dr. _____

_____ Dr. _____

Patient Signature: _____ Date: _____

MRN:

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CONSENT TO TREATMENT, USE OF HEALTH INFORMATION AND RECORDING

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

AUTHORIZATION FOR TREATMENT

Patient Initials: _____

I authorize Rocky Mountain Oncology and its physicians, advanced practice providers, nurses, employees, contractors, and other authorized health care professionals to provide diagnostic procedures, examinations, testing, medical treatment, surgical treatment when applicable, follow-up care, and other health care services deemed reasonably necessary for the evaluation, diagnosis, treatment, and management of my condition. I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made regarding the results of any examination, procedure, treatment, or service. I understand that, except in emergency or extraordinary circumstances, I will have the opportunity to discuss recommended treatments or procedures with my provider and ask questions before deciding whether to proceed. I understand that I have the right to consent to, refuse, or withdraw consent for any proposed treatment to the extent permitted by law. I further understand that tissues, specimens, or samples obtained during treatment may be examined, tested, retained, or disposed of in accordance with applicable law and accepted medical practices. I understand that photographs, videos, telehealth/telemedicine images, digital images, and other clinical recordings may be created or used as reasonably necessary to document my care and may become part of my medical record. Such records will be maintained in a secure manner designed to protect my privacy and will not be released except as permitted by law or authorized by me.

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

Patient Initials: _____

I understand that my protected health information may be used and disclosed for treatment, payment, and health care operations as permitted by law. I acknowledge receipt of, or the opportunity to review, the Notice of Privacy Practices.

FINANCIAL RESPONSIBILITY

Patient Initials: _____

I understand that I am financially responsible for charges incurred for services rendered, including any amounts not paid by my insurance carrier.

ASSIGNMENT OF INSURANCE BENEFITS

Patient Initials: _____

I authorize and assign payment of medical benefits directly to the practice for services rendered.

MEDICARE AND GOVERNMENT PROGRAM AUTHORIZATION

Patient Initials: _____

If applicable, I authorize the release of information necessary to process claims for Medicare or other government benefit programs and request payment of authorized benefits directly to the practice.

MANAGED CARE ACKNOWLEDGMENT

Patient Initials: _____

I understand that certain health plans may require referrals, prior authorizations, or other approvals before services are covered and I may be financially responsible when required approvals are not obtained.

MRN:

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CONSENT TO TREATMENT, USE OF HEALTH INFORMATION AND RECORDING

CARE MANAGEMENT SERVICES

I give permission to Rocky Mountain Oncology to provide care management services as part of my overall medical services. Services include help with coordinating my cancer care between visits, accessing community resources, and understanding my treatment for cancer. I may withdraw my consent at any time by notifying the practice in writing.

AI ASSISTED DOCUMENTATION AND AUDIO RECORDING

To support accurate documentation of my visit, the practice may utilize a secure artificial intelligence (AI) assisted documentation tool. When used, the technology may process audio from conversations occurring during my visit for the purpose of generating a draft clinical note. This may include the voices of any family members, caregivers, or other individuals present with me during my visit, and I understand that their statements may also be recorded and processed by this technology. By consenting below, I and any other person present during my visit are consenting to have our voices recorded during this appointment. Some states require the consent of everyone present before a conversation may be recorded. By signing below, I confirm that I have obtained, or will obtain, the consent of any other person present at my visit before the AI tool is used. My provider remains responsible for reviewing, editing, and approving all documentation before it becomes part of my medical record. The AI technology is used solely as a documentation support tool and does not replace professional medical judgment.

☐ **I CONSENT** to the use of AI-assisted documentation during my visit, including recording of my visit necessary to create the clinical documentation.

☐ **I DECLINE** being recorded and the use of AI-assisted documentation during my visit. I understand that declining will not affect my ability to receive care or treatment.

OTHER PERSONS PRESENT DURING MY VISIT

This consent covers all individuals present during my visit, including family members, caregivers, friends, interpreters, students, or other observers (each, an "Other Person Present"). By remaining in the room while the AI tool is in use, each Other Person Present acknowledges that their statements may be heard, recorded, transcribed, and used in the same manner described in the AI Assisted Documentation & Audio Recording section above. If any Other Person Present does not wish to be recorded, please tell your provider before your visit begins so the AI tool can be paused while that person is in the room, or so that person may step out during its use.

PATIENT ACKNOWLEDGMENT (Please Print Clearly)

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Representative Name (if applicable): _____

Relationship to Patient: _____

Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Other Person(s) Present Name(s) and Signature(s) (if any): I am present during this visit and consent to the recording of my statements as described above.

Name: _____ Date: _____

Signature: _____

MRN:

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LATE ARRIVAL POLICY AND ELECTRONIC COMMUNICATION POLICY

ELECTRONIC COMMUNICATIONS

For your convenience, our office communicates through different electronic means including our secure patient portal, phone and text messaging for appointment reminders.

How may we contact you? (Check all that apply)

- ☐ Home Phone _____
- ☐ Work Phone _____
- ☐ Cell Phone _____
- ☐ Text Messages _____
- ☐ Email _____
- ☐ Patient Portal

May we leave a detailed message ☐ Yes ☐ No

If someone else answers the phone, may we leave a message? ☐ Yes ☐ No

LATE ARRIVAL POLICY

Patients arriving more than 10 minutes late for a scheduled office visit or procedure appointment will be rescheduled for another day.

PATIENT CODE OF CONDUCT

We are committed to providing a safe, respectful, and supportive environment for our patients, visitors, and staff. We ask that everyone communicate and interact with courtesy and respect. Behavior that is threatening, abusive, harassing, physically aggressive, or disruptive to patient care may result in appropriate action, consistent with applicable law, patient care obligations, and practice policies, including being asked to leave the premises, involvement of law enforcement when necessary, and, where appropriate, discharge from the practice.

By signing this form, you acknowledge and support our commitment to maintaining a safe and respectful environment for all.

Signature of Patient or Representative: _____ Date: _____