

Patient Information and Authorizations

Date:

Doctor:

Location:

Patient's Name: _____ Patient Number: _____

Street Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____ County: _____
Patient's Social Security Number: _____ Birthdate: _____ Sex: M F
Patient's Employer: _____
Employer's Address: _____ Work Number: _____
Marital Status: Single Married Divorced Widowed Spouse Name: _____
Spouse's Social Security Number: _____ Birthdate: _____
Spouse's Employer: _____
Employer's Address: _____ Work Number: _____
Emergency Contact: _____ Phone Number: _____

Medicare Number: _____ Medicaid Number: _____
Is your Medicare Primary? Yes No
Name of Primary Insurance Plan: _____
Please check appropriate box: Group Private Cancer Medicare Supplement
If Group Insurance, are you covered by your spouse or parent's insurance? Yes No
Name of beneficiary on insurance card _____ SS# _____
Policy Number: _____ Group Number: _____
Name of Subscriber: _____ Birthdate: _____
Address to mail claim: _____
Does your insurance require you to have a primary care physician? If so, what is the name of your primary care physician? _____

Does your primary insurance require referral numbers? Yes No Does your primary insurance require precertification? Yes No If yes to either of the above questions, please give us the phone number to call:

Does your primary insurance require you to use a specific lab? Yes No

If yes, name of lab _____

Name of Secondary Insurance Plan: _____

Please check appropriate box: Group Private Cancer Medicare Supplement

Policy Number: _____ Group Number: _____

Name of Subscriber: _____ Birthdate: _____

Address to mail claim: _____

Does your insurance require you to have a primary care physician? If so, what is the name of your primary care physician? _____

Does your secondary insurance require referral numbers? Yes No Does your secondary insurance require precertification? Yes No If yes to either of the above questions, please give us the phone number to call:

Does your secondary insurance require you to use a specific lab? Yes No

If yes, name of lab: _____

PRECERTIFICATION AND REFERRALS

If your insurance company requires preadmission certification or office referrals, it is your responsibility to see that we notify your insurance company prior to all admissions or office visits. Any charges not covered as a result of noncertification is your responsibility.

Patient's Signature: _____

OFFICE FINANCIAL POLICY

INSURANCE AUTHORIZATION: I request that payment under the medical insurance program be made either to me or to the provider for any bills for services rendered to me during the effective period of this authorization. I authorize this provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims I may use.

Patient's Signature: _____

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs, and reasonable legal fees.

Responsible Party's Signature: _____

CHEMOTHERAPY CAN BE VERY COSTLY. PRIOR TO THE START OF TREATMENT, WE CAN PROVIDE A DETAILED STATEMENT OF THE EXPECTED COSTS. PLEASE BE SURE TO ASK FOR AN ESTIMATED COST SHEET, IF YOU HAVE CONCERNS ABOUT YOUR INSURANCE COVERAGE. THE PATIENT RESOURCE COORDINATOR IS AVAILABLE TO ASSIST YOU.

CONSENT TO RELEASE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR PRACTICE OPERATIONS

I authorize Summit Cancer Care to obtain or release any medical information necessary to provide medical services to me and / or to process insurance claims. In addition, I authorize Summit Cancer Care to release any of my medical information that is required for any health care related utilization review, quality assurance activities or other healthcare operations.

I understand medical information to be disclosed may include history and physical examinations, consultation reports, x-ray reports, discharge summaries, progress notes, laboratory tests and photographs, videotapes, digital or other images.

I am aware and specifically waive any privilege regarding the following information that may or may not be contained in my medical record:

- Communications between patient and psychiatrist
- Communications between patient and psychologist
- Medical information concerning drug dependency
- Medical information concerning alcohol and drug dependency
- Medical information concerning alcohol and drug abuse
- Medical information concerning mental retardation
- Medical information concerning HIV / Acquired Immune Deficiency Syndrome

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. A photocopy of this consent shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this consent. I acknowledge that I have received a copy of "Notice of Privacy Practices" which outlines how medical information may be used and disclosed as well as how I might obtain an explanation as to what entities my information has been released.

Following is a list of name/s of any family members, friends and/or significant other who may discuss my care with my physician or other clinical staff and receive information concerning my diagnosis and treatment with or without me present during the discussion.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Date _____ Signature _____

(Patient or Authorized Individual)

Witness _____ Relationship _____