Patient/Responsible Party Information

Patient Name:____
(First) (Middle) (Last)

Date of Birth:__________________Age:_______Sex:_______Social Security No.______________

Marital Status (circle one): Single Married Widowed Separated Divorced

Mailing Address:____

City:______________________________State:__________Zip:__________

Physical Address (if different from mailing):______________________________

City:______________________________State:__________Zip:__________

Home Phone:__________________Cell:__________________Work:__________________

Which number do you prefer we use to contact you?__________________ Can we leave a message? ☐Yes ☐No

Email Address:__________________________@__________________________

Race: White☐ Black/African American☐ Asian☐ American Indian or Alaska Native☐ Native Hawaiian or Other Pacific Islander☐

Ethnicity: Hispanic or Latino☐ Non Hispanic or Latino☐ Decline to Answer☐

Primary language spoken at home:__________________________ Are you a Veteran? ☐Yes ☐No

Employer:______________________________Occupation:______________________

Spouse's Name:__________________________DOB:__________SSN:______________

Spouse's Employer:__________________________Spouse's Phone:______________

Do you give us permission to send your personal medical record to your secure Patient Portal? ☐Yes ☐No

Do you have an Advanced Directive? ☐Yes ☐No (If yes, please provide document.)

<u>Responsible Party (if other than patient):</u>

Name:__________________________DOB:__________Relationship to Patient:______________

Address:__________________________City:__________ST:______Zip:__________

Home Phone:__________________Cell:__________________Work:__________________

<u>Emergency Contact – Please list the closest friend or relative not living with you.</u>

Name:______________________________Relationship:______________________

Address:__________________________City:__________ST:______Zip:__________

Home Phone:__________________Cell:__________________Work:__________________

Referring Physician:______________________________Phone:__________________

Primary Care Physician:__________________________Phone:__________________

Primary Insurance Information

Company:______________________________ Phone:______________

Policy Holder:______________________ DOB:________ Relation:__________

Policy/Member Number:______________________ Group Number:______________

Secondary Insurance Information

Company:______________________________ Phone:______________

Policy Holder:______________________ DOB:________ Relation:__________

Policy/Member Number:______________________ Group Number:______________

To the best of my knowledge, all of this information is true and correct. I understand that I am responsible to pay for all services rendered to me and that I am willing to make specific arrangements to pay what is not covered by insurance on a timely basis. (PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT.) I grant permission to my physician to mutually exchange medical information with my referring physician(s) and/or their associates. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record to my insurance and medi-gap carriers. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain In effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature:______________________________________ Date:______________

Spouse's Signature(if applicable):______________________________ Date:______________

ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made directly to HIGHLANDS ONCOLOGY GROUP for any service provided to me by HIGHLANDS ONCOLOGY GROUP. I authorize HIGHLAND ONCOLOGY GROUP to release information to HCFA and its agents any information needed to determine benefits.

Signature:______________________________________ Date:______________