North County Oncology

New Patient Form

PATIENT INFORMATION Date: _____________

Name ____ Birthdate ____________________________
Social Security Number ___________________________ CA Driver's License Number ______________________

Home Address ____City___________________ Zip ____________

Home Phone ________________Cell _______________ Primary Care Physician __________________________

Employer ____ Occupation_________________________________
Phone _________________________________

Name of Spouse/Relative ____ Relationship ___________________
Phone_______________ Name of Emergency Contact *(if not listed above)* _________________________________

Relationship ____________________________________ Phone _______________________________________

PHARMACY _______________________________________ Phone ____________________________________

PRIMARY INSURANCE

Name ____ Policy Number __________________________________
Group Number __________________________ Insured ____

Address ____

Is Pre-certification required? Yes _______ No________

SECONDARY INSURANCE

Name ____ Policy Number __________________________________
Group Number __________________________ Insured ____

Address ____

Is Pre-certification required? Yes _______ No________

All professional fees are due at the time of service, unless previous arrangements are made. As a courtesy, our office will file your Insurance, if proper information is received. You are required to pay your co-payments at the time of visit.

PATIENT AUTHORIZATION

I authorize North County Oncology to submit Medicare or other insurance claims using my signature on file below. I authorize the release of medical information necessary in order to process this assignment of the claim. I authorize payment of medical benefits to be paid directly to the physician indicated for services rendered. I realize that this may not represent the full payment for services rendered and I will be responsible for balance due.

Patient Signature ____ Date _________________________

North County Oncology

Insurance Disclaimer

please read carefully

When we call on your insurance and verify benefits it is not a guarantee of payment. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

It is ultimately up to you to make sure North County Oncology doctors are within your plan.

Please remember that the contract itemizing your medical benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of visit.

I, ____________________________ , have chosen to allow North County Oncology to file my insurance and accept full responsibility for this account.

I understand it Is my responsibility to be aware of what type of medical plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits.

Print Name ____ Date _________________________

Patient Signature ____ Date __________________________

Staff Signature ____ Date _________________________

North County Oncology

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____________________________________, acknowledge that I have
(Print Name of Patient)

received a copy of North County Oncology Medical Clinic, Inc. Notice of Privacy Practices. This Notice describes how North County Oncology Medical Clinic, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. Disclosure of my protected health information shall become effective immediately and shall remain in effect as long as I am a patient of North County Oncology Medical Clinic.

____

Signature of Patient, or Personal Representative

____

Date

____

Relationship to Patient

North County Oncology

HIPPA Authorization

permission from patient/ patient's legal guardian to share personal medical information

Patient Name ____________________________________ Date of Birth_________________________________

Home Address ____City___________________ Zip ____________

I, _____________________________________, hereby authorize North County Oncology Medical Clinic, Inc. to
(Print Name of Patient)

release any and all medical information and test results that pertain to me, to the following individual(s):

Name	***Phone Number***	***Relationship***

I authorize North County Oncology Medical Clinic, Inc. to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying North County Oncology Medical Clinic, Inc. in writing of my intent to revoke authorization or change the name(s) of the individuals to whom my information is to be released.·

____

Signature of Patient, or Personal Representative

____

Date

____

Relationship to Patient

North County Oncology

Current Medication List

Patient Name ___________________________ Date of Birth________________ Today's Date ______________

Medication Name	*Dose*	*Frequency*

Allergies	*Reaction*