Northern Virginia Hematology & Oncology Associates

We fight cancer, all day, everyday.

We Appreciate the Opportunity of Serving you. We Pledge to Give you Our Best Medical Care.

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

ADDRESS:_____ CITY, STATE, ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE:_____ EMAIL:_____

EMPLOYER:_____ ADDRESS:_____

PLEASE CHOOSE WHICH NUMBER(S) WE MAY LEASE MESSAGES AT: ☐ HOME ☐ CELL ☐ WORK

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT:_____ PHONE:_____

RELATIONSHIP:_____

PRIMARY CARE PHYSICIAN:_____ REFERRED BY:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

POLICY HOLDER NAME:_____ POLICY HOLDER DATE OF BIRTH:_____

INSURANCE ID:_____

POLICY HOLDER RELATIONSHIP TO YOU: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER_____

SECONDARY INSURANCE:_____

POLICY HOLDER NAME:_____ POLICY HOLDER DATE OF BIRTH:_____

INSURANCE ID:_____

POLICY HOLDER RELATIONSHIP TO YOU: ☐ SELF ☐ SPOUSE ☐ PARENT

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☐ OTHER_____

MEDICATION LOG

PATIENT NAME:_____ DATE OF BIRTH:_____
PREFERRED PHONE:_____ ☐ HOME ☐ CELL ☐ WORK
OCCUPATION:_____
PHARMACY:_____ PHARMACY PHONE:_____
ALLERGIES: _____

Medication Name	Start Date	Dosage	Frequency	Who prescribes it?

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Release of Information

Many of our patients allow family members such as their spouse, significant other, parent or children to call and request the patient's medical information. Under the requirements for H.I.P.A.A we do not have permission to give this information to anyone without the patient's signed consent. If you wish to have your medical information released to any family members you must sign this form.

Patient name:_____ Date of birth:_____

⬜ Spouse:_____

⬜ Children:_____

⬜ Other:_____

⬜ Medical information may not be released to anyone

Messages

The best time to reach me is (day)_____ between(time)_____

If unable to reach me:

⬜ You may leave a detailed message

⬜ Leave only a message requesting a call back

⬜ Other _____

This release of information will remain in effect until terminated by me in writing.

Patient signature:_____ Date:_____

Guardian or witness Signature:_____ Date:_____

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Consent for Release of Healthcare Information Form

I authorize the Doctor to release any medical information including diagnosis, radiology results, laboratory results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of this information.

Patient name:_____

Previous name:_____

Date of Birth:_____ social security number:_____

I authorize and request _____ to release healthcare information of the patient named above to:

Northern Virginia Hematology and Oncology Associates

The request and authorization apply to:

⬜ Healthcare information relating to the following treatments, conditions, or dates:

_____

⬜ All healthcare information

⬜ Other:_____

This release of information will remain in effect until terminated by me in writing.

Patient signature:_____ Date:_____

Guardian or witness Signature:_____ Date:_____

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Office Policy on Payments and Insurance

Office Payment Policy

It is our policy to require payment for all office charges at the time services are rendered, unless prior arrangements have been made.

- All accounts over **60 days** past due will be assessed an interest charge of **1.5% per month** (18% per annum) or a **$2.00 minimum**, whichever is greater.
- In the event that a balance is not paid as agreed, the undersigned **jointly and severally agree** to pay all fees assessed by a collection agency (not to exceed 20% of the unpaid balance), including reasonable attorney's fees.
- **New patients** will be charged a **$25.00 rescheduling fee** if the office is not notified of a cancellation **at least 24 hours** prior to the scheduled appointment.

Insurance Policy

Insurance is a contract between you and your insurance carrier for reimbursement of allowed medical charges.

As a **courtesy**, we will:

- Provide you with an **itemized statement** to submit to your insurance company, **or**
- **Submit claims** to most insurance carriers **if** you provide us with:
    - Policy numbers
    - Insurance company address
    - Employer information
    - Any other required details

Please note:

- You are **responsible** for all **deductibles**, **copayments**, and any charges **not covered** by your insurance.
- We **cannot act as a third party** in extended insurance negotiations. Any follow-up with your insurance is **your responsibility**.

Authorization and Acknowledgment

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. This authorization may be **revoked in writing** by either myself or my insurance company at any time.

I have read and understand the above policy and accept **full financial responsibility** for my account.

Signature: _____
Printed Name: _____
Date: _____