Central Coast Oncology and Hematology

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Información del Paciente (Por favor use letra de molde)

Paciente (Apellido, Nombre)			
Dirección Postal		Empleador	
Ciudad, Estado	Código Postal	Estado Civil	Sexo
Num. de Seguro Social	Tel. de casa	Fecha de Nacimiento	Edad
Tel. de trabajo	Tel. celular	Correo Electrónico	
Preferencia método de contacto (circulo) Casa Trabajo Celular Correo Electrónico		Idioma Principal (circulo) Ingles Español Otra:_____	
Raza (circulo) Indio Americano/Nativo de Alaska Asiático Norteamericano Africano Nativo de Hawái/ Origen de las Islas del Pacifico Caucásico Otra Me niego a contestar			
Etnicidad (circulo) Hispano, Latino, o de origen Español Non-Hispano, Non-Latino, ni de origen Español Me niego a contestar			
Persona en caso de emergencia (Apellido, Nombre)			
Relación al paciente		Teléfono	

Información de Seguro

Medico Primerio		Medico referido	
Persona responsable del pago de la cuenta (Apellido, Nombre)			
Dirección Postal		Relación al paciente	
Ciudad/Estado	Código Postal	Fecha de Nacimiento	
Num. de Seguro Social	Teléfono	Empleador	
Seguro Primerio		Seguro Secundario	
Num. de político		Num. de política	
Num. de grupo		Num. de grupo	
Razón Medicare esta secundario			

La información anterior es verdadera según mi entender. Autorizo a mi compañía de seguros a pagar a Central Coast Oncology & Hematology. Entiendo que soy responsable financieramente por cualquier cuenta no más de 60 días del día de servicio.

Firma del Paciente/Guardián _____ Fetcha_____

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Consent to Treat

I consent to any examination or procedure rendered me under the instructions of my physician. I recognize the physicians furnishing services to me are independent agents.

Initial _____

Assignment of Benefits to Physician

I hereby give authorization for payment of insurance benefits to be made directly to **Central Coast Oncology & Hematology** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Our Managed Care patients will be responsible for all non-covered services as outlined by their plan. In the event of a default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize **Central Coast Oncology & Hematology** to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Initial _____

Medicare Authorization to Pay Benefits to Physician

Beneficiary Name _____ HIC# _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Central Coast Oncology & Hematology** for any services furnished to me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have had the opportunity to read/receive a copy of the Notice of Privacy Practices of **Central Coast Oncology & Hematology**.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Address

_____ _____
Telephone (day) Telephone (evening)