Anderson Area Cancer Center
Oncology-Hematology Clinic, P.A.

2000 E. Greenville Street, Suite 5000, 1st floor
Anderson, SC 29621
Phone No. (864) 512-1658
Fax No. *864) 512-6845

John E Doster, MD
James T. McClain, MD
Jeffrey S. Delo, MD
Jay B. Nayak, MD
Sarah Brendle, PA-C
Margaret Kelley,APRN

We have prepared this packet of patient forms to help make your first visit a convenient and pleasant experience. We ask that you complete the attached paperwork to arrival.

When you come for your appointment, please bring the following:

- Completed Patient Registration Form
- Insurance Cards
- Picture ID

Please be prepared to pay for the following at the time of your visit:

- Co-payment that your insurance allows (Our office accepts cash, check, VISA, Master Card, American Express, or Discover).
- If you do not have insurance, you will be responsible for the office visit co-payment and any additional services the day of your visit.

If you are unable to complete your paperwork prior to arrival, please arrive 10 minutes early for your appointment. If you bring your completed paperwork with you, you are welcome to arrive 5 minutes early or just in time for your appointment.

Thank you,
Anderson Area Cancer Center

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Patient Information
First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____Gender: M F Unknown Race: _____

Language: _____ Marital Status: Married Single Divorced Widowed Separated

Date of Birth: _____SSN: _____

Home Address: _____
Street City State Zip Code

Billing Address: _____
Street/PO Box City State Zip Code

Home Phone: (___)_____Cell Phone: (___)_____Work Phone: (___)_____

Email: _____ Would you like to be enrolled in the patient portal? Yes / No

Employment Status: Full Time Part Time Retired Unemployed Disabled

Primary Insurance: _____ **Secondary Insurance:** _____

Preferred Pharmacy: _____Phone: (___) _____

Emergency Contact:

Name: _____ Phone #: (___) _____Relationship: _____

Name: _____ Phone #: (___) _____ Relationship: _____

Family Physician: _____ Phone #: (___) _____

Referring Physician: _____ Phone #: (___) _____

Advanced Directive: YES NO

Signature certifies that the information above is correct. I give consent to be treated by Anderson Area Cancer Center.

Patient Signature _____Date _____

Responsible Party/Personal Representative _____Date _____

Oncology-Hematology Clinic, P.A.

CONSENT TO TREAT, INSURANCE, ASSIGNMENTS, FINANCIAL AGREEMENT,
AUTHORIZATION TO RELEASE INFORMATION AND
PRIVACY NOTICE AKNOWLEDGEMENT

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider. Which may include but is not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician.
2. ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION. In consideration of services rendered, I hereby transfer and assign to Anderson Area Cancer Center all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer.
3. FINANCIAL AGREEMENT. The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney fees and collection expenses. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.
4. MEDICARE/ MEDICAID. Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.
5. USE OF COPIES. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic.
6. PAYMENT AND RESPONSIBILITY. I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay for any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD-PARTY PAYOR WITHING A REASONABLE PERIOD OF TIME NOT TO EXCEED 120 DAYS or call the office to make payment arrangements.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received on this, or on a prior occasion, Anderson Area Cancer Center's Notice of Privacy Practice and acknowledge that I have a copy of the notice or that I requested and was given a copy.

Patient/legal Representative Signature: _____

Date: _____

Patient refused to sign Acknowledgement: Staff Signature: _____

Anderson Area Cancer Center

Oncology-Hematology Clinic, P.A.

HIPAA RELEASE/Authorization

This patient (or authorized person) signed form authorizes Anderson Area Cancer Center to obtain, use, or disclose Protected Health Information (PHI) in the course of providing patient health care.

PHI may include any medical records such as: Lab, X-Ray, PET, CT, MRI, etc. results; personal medical history, physician notes and correspondence, Power of Attorney, Living Will, medication lists, hospital or assisted facility records, billing and insurance information.

1. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide the names of those individuals on the HIPAA Disclosure Release Form provided to me by Practice. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

2. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including, but not limited to: (i) healthcare-related information, including appointment reminders, discharge instructions, pre-operative or post-operative instructions, follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, follow-ups related to a visit or other interaction, information about my condition(s), diagnosis, treatment plan, available treatment options and capabilities, reference materials, information about programs or services that might be of interest to me, invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information or records, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to practice Patient billing information.

   I expressly agree and consent that you, your customer service personnel, your billing service provider and/or collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or you, your customer service personnel, your billing service providers and/or collection agents have obtained or, at any number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. Methods of contact may include using pre-

recorded/artificial voice messages and/or use of an automated dialing device, as applicable. I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include your name, date/time of appointments, physician/practice name, physician/practice specialty, patient account number or other information related to your financial obligation or our services. Message and data rates may apply to text messages. Additional text messaging terms may be located on the Provider's website and may be updated from time to time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can opt out of receiving additional messages of such type, by notifying The Practice in writing of my desire to opt-out of receiving such type of message, but I may continue receiving text messages of other types subject to separate opt-out notification.

____YES, text (SMS) messages and notifications

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state la

Write in the names of ONLY the people you want to receive your health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Physician Practice Services, and that I have signed this Conditions of Physician Practice Services knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Patient Representative Signature :

X_____ **Date :** _____

If you are not the Patient, please identify your Relationship to the Patient.

(Mark relationship(s) from list below):

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Neighbor/Friend
- ☐ Sibling
- ☐ Healthcare Power of Attorney
- ☐ Guarantor

Anderson Area Cancer Center

Release of Medical Information

2000 E. Greenville Street, Suite 5000
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Sarah Brendle, PA-C Margaret Kelley, APRN

Patient Information:

Name _____ DOB _____

Address _____
Street City State Zip Code

Name of covered entity authorized to release information:

Release medical records to Anderson Area Cancer Center at the request of the patient.

Reason for request: Continuation of care

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effective until the requested items have been delivered or the information has been reviewed by the patient.

_____ _____
Print Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Date

Personal Representative MUST provide copy of authority (Power of Attorney, Trust, Living Will, etc.)