Anderson Area Cancer Center
Oncology-Hematology Clinic, PA

2000 E. Greenville St, Suite 5000
Anderson, SC 29621
Ph. (864)224-5765
Fax (864)224-1449

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We have prepared this packet of patient forms in order to help make your first visit a convenient and pleasant experience. We ask that you complete the attached paperwork prior 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 paper work prior to arrival please arrive 20 minutes early for your appointment. If you bring your completed paperwork with you, please check in 15 minutes prior to your scheduled appointment time to allow our office time to complete the administrative portion of your appointment and have your chart ready for the appointment.

Thank You,

Anderson Area Cancer Center

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

2000 E. Greenville Street, Suite 5000 Anderson SC, 29621
Phone 864-224-5765 Fax: 864-224-1449

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

Gender: M F 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: _____ Patient Portal? Yes / No

Race: _____ Language: _____

Employment Status: Full Time Part Time Retired Unemployed Disabled

Preferred Pharmacy: _____ Phone: _____

Emergency Contact:
Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Insurance Information:
Primary Insurance: _____ ID #: _____ Group # _____

Insured's Name _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID#: _____ Group # _____

Insured's Name _____ DOB: _____ SSN: _____

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 _____

Anderson Area
CANCER CENTER
Survive. Thrive. Rejoice.

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 are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician._____(initials)
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._____(initials)
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's fees and collection expense. 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._____(initials)
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._____(initials)
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._____(initials)
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 procedure, and others pay a percentage of the charges. I understand it is my responsibility to pay 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._____(initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received on this, or on a prior occasion, Anderson Area Cancer Center, 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:

_____Date:_____

Witness:

_____Date:_____

Patient refused to sign Acknowledgment:

PATIENT'S SIGNATURE: _____DATE_____

SUBSCRIBER SIGNATURE (if different than patient):_____

FOR OFFICE USE: REGISTRATION COMPLETED BY: _____DATE:_____

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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.

Name of Patient (print):_____Birth Date:_____

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

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

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 as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

X_____Date_____

Signature of Patient or Personal Representative (as defined by HIPAA)

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