STATEN ISLAND RADIATION ONCOLOGY

1781 HYLAN BLVD
STATEN ISLAND, NY 10305

Date_____

Patient RT # _____

PATIENT INFORMATION:

_____ _____
First Name MI Last Name Date of Birth Age

_____
Address apt# City State Zip

_____
Home Phone Work Phone Cell/Message Phone

_____ M/F_____ _____ S, M, W, D_____
Social Security Number Sex Ethnicity Marital Status

_____
If retired, date If disabled, date From what company?

_____
Employer Employer address Employer Phone#

INSURANCE INFORMATION:

_____
Primary Insurance Medical Group (HMO) ID# Group #

_____
Name/Relation of Policyholder Social Security No. Policy Date of Birth Policyholder

_____
Secondary Insurance Medical Group (HMO) ID # Group #

_____
Name/Relation of Policyholder Social Security No. Policy Date of Birth Policyholder

_____
Policyholder Employer (if other than patient) Employer's Address Employer Phone

_____
Primary care Physician Phone #

_____
Referring Physician Phone#

EMERGENCY CONTACT:

_____
Name Relationship

_____
Address Phone #

PHARMACY INFORMATION:

_____
Your Pharmacy Name Pharmacy Phone Number

STATEN ISLAND RADIATION ONCOLOGY **1781 Hylan Blvd**
Statement of Patient financial Responsibility **Staten Island, NY 10305**

Patient name_____ **DOB**_____

Staten Island Radiation Oncology appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim or if your physician elects to continue past your approved period you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to **STATEN ISLAND RADIATION ONCOLOGY** for providing rehabilitative services to me or the above named patient. I certify that the information is to the best of my knowledge true and accurate. I authorize my insurer to pay any benefits directly to Staten Island Radiation Oncology the full and entire amount of bill incurred by me or the above named patient or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature_____ **Date**_____

Guarantor Signature_____ Date_____
(If guarantor is not patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature_____ **Date**_____

Consent for Treatment and Authorization to Release Information

I hereby authorize **STATEN ISLAND RADIATION ONCOLOGY** through its appropriate personnel to perform or have performed upon me or the above named patient appropriate assessment and treatment procedures.

I further authorize **STATEN ISLAND RADIATION ONCOLOGY** to release to appropriate agencies any information acquired in the course of my or the above named patient examination and treatment.

Patient/Guarantor Signature_____ **Date**_____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Cesaretti Oncology. I agree to pay Cesaretti Oncology the full and entire amount for treatment given to me or the above named patient at each visit.

Patient/Guarantor Signature_____ **Date**_____

STATEN ISLAND RADIATION ONCOLOGY

1781 HYLAN BLVD
STATEN ISLAND, NY 10305

Authorization for Release of Medical Records

I hereby authorize_____

To release information from the medical records of _____

Patient Name_____

Date of Birth_____ Social Security # _____

Records requested (specifically):

_____

_____

_____

_____

_____

Patient's Signature _____ **Date** _____

Please forward records to: _____

Address:_____

Phone # _____

Fax # _____

STATEN ISLAND RADIATION ONCOLOGY **1781 HYLAN BLVD**
STATEN ISLAND, NY 10305

Patient Confidentiality Agreement

If you are unable to be contacted by our office, please specify any family member or friend that we can release any or all information relating to your medical condition.

	NAME	RELATIONSHIP	PHONE #
1.			
2.			
3.			
4.			
5.			

As a result of signing this agreement, you allow the doctors and all staff of Staten Island radiation Oncology access to your medical records and the release of medical information to the persons listed above.

_____ _____
Patient / Guardian Signature Date

_____
Print Patient Name

STATEN ISLAND RADIATION ONCOLOGY **1781 HYLAN BLVD**
STATEN ISLAND, NY 10305

AGREEMENT FORM

The patient is authorizing the Physician to deposit checks received on patient's account when they are made out to the patient.

Patient signature: _____

Date: _____

STATEN ISLAND RADIATION ONCOLOGY

1781 HYLAN BLVD
STATEN ISLAND, NY 10305

Physician Contact Information:

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at this time, please, call us when you get home. This information is very important so that we can inform your physicians of your progress.

Primary Physician: _____

Phone: _____

Referring Physician: _____

Phone: _____

Other Physician: _____

Phone: _____

Other Physician: _____

Phone: _____

Other Physician: _____

Phone: _____

Other Physician: _____

Phone: _____

STATEN ISLAND RADIATION ONCOLOGY **1781 HYLAN BLVD**
STATEN ISLAND, NY 10305

Assignment of Benefits Form

Name of Patient (Print): _____

Social Security Number: _____

I request that payment of official insurance benefits, including Medicare benefits, be made on my behalf to the organizations listed below for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to such organizations, the Centers for Medicare and Medicaid Services (CMS), my insurance carrier or other medical provider. A copy of this authorization may be sent to CMS, my insurance company or other medical provider is requested.

I understand that I am financially responsible to the organizations for any changes not covered by my health care benefits. It is my responsibility to notify the organizations of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for all payment for services or products received. By signing this agreement, I also acknowledge that I have received a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

_____

Signature of Patient or Patient Guardian

_____

Relationship to Patient (If patient not signing)

_____

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CA GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose or evaluating your health, diagnosing medical conditions and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Staten Island Radiation Oncology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy our protected health information.
- The right to amend or submit corrections to you protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Staten Island Radiation Oncology 1781 Hylan Blvd, Staten Island, NY 10305 Ph: (718) 351-9750 Fax: (718) 351-9756

Staten Island Radiation Oncology Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy polices and practices that outline in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our polices and practices may be required by changes in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised polices and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Staten Island Radiation Oncology
Staten Island, NY 10305

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practice is:

Office Manager
Staten Island Radiation Oncology
Staten Island, NY 10305

Effective Date

This notice is effective on or after January 01, 2016

Staten Island Radiation Oncology

1781 HYLAN BLVD
STATEN ISLAND, NY 10305

Your signature is an acknowledgement of receipt that you have read the Notice of Privacy Practices. If you request a copy of your notice it will be provided.

Patient's Signature _____

Date _____

STATEN ISLAND RADIATION ONCOLOGY **1781 HYLAN BLVD**
STATEN ISLAND, NY 10305

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to STATEN ISLAND RADIATION ONCOLOGY of the insurance benefits to which I may be entitled. Requested information may be released the insurance carrier.

MEDICARE PATIENTS

Patients Medicare Number: _____

Medicare Authorizations (for signature on file): I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment.

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 hereby individually obligates himself/herself to pay the account of patient.

Patient name (print) _____

Patient Signature _____ Date: _____

Relationship if not Patient Signature _____

A photocopy of this form may be deemed valid