WESTERN RADIATION ONCOLOGY

NEW PATIENT REGISTRATION

Date: _____

Patient's Name: _____
Last Name First MI

Date of Birth: _____ ☐ Male ☐ Female **Marital Status:** S M W D **Age** _____

Street Address: _____ **City:** _____

State/zip code: _____ **Home Phone #:** (_____) _____ -- _____

Cell Phone #: (_____) _____ -- _____ **Social Security #:** _____

Email Address _____ **Pharmacy**_____

Patient's Employer: _____ **Work Phone #:** (_____) _____ -- _____

Is this work-related? ☐ Yes ☐ No **If yes, date of injury:** _____ **Claim #:** _____

Spouse's Name: _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Primary Insurance Policy #: _____ **Group #:** _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Subscriber's Name: _____ **Subscriber's DOB:** _____

SECONDARY INSURANCE CARRIER: _____

Secondary Insurance Policy #: _____ **Group #:** _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Subscriber's Name: _____ **Subscriber's DOB:** _____

PHYSICIAN INFORMATION

Referring Physician's Name: _____ City: _____

Primary Care Physician: _____ City: _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Phone #: (_____) _____ -- _____ Relationship to Patient: _____

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Western Radiation Oncology to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Western Radiation Oncology. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Western Radiation Oncology are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

_____	_____	_____
Signature of Patient, Parent or Legal Guardian	**Relationship to Patient**	**Date**

WESTERN RADIATION ONCOLOGY

BILLING AND FINANCIAL POLICY – pg. 1

The following sets forth the policies of Western Radiation Oncology. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Western Radiation Oncology with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

- I understand that a cancellation fee of $50.00 may be billed directly to myself if a 48-hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment.

- I understand that a surgery cancellation fee of $250.00 may be billed directly to myself. This fee will be assessed if cancellation of the surgery has not been made 7 days prior to scheduled surgery date. This fee must be cleared with our financial office before surgery can be rescheduled.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. Western Radiation Oncology and/or its representatives will make every effort to assist you but Western Radiation Oncology will not be held accountable for understanding every insurance plan.

- I understand that there is a $20.00 fee (per form) to complete disability paperwork associated with my care.

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that **ANY FEES I AM QUOTED ARE ESTIMATED** based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

BILLING AND FINANCIAL POLICY – pg. 2

- I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Western Radiation Oncology.

_____ _____

Legal Signature Date

_____

Print Patient's Name

_____

Relationship to Patient

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent *via* fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Western Radiation Oncology, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Western Radiation Oncology only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.

- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.

- You have the right to request in writing to inspect and/or receive a copy of your health information. * Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., *via* telephone text or email).

- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  * Conditions and limitations may apply; obtain additional information from our Privacy Officer.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent *via* Text, *via* email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ DATE OF BIRTH: _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name, alternative address, phone number, & email address of Spouse, as applicable:** _____

  ☐ **OK to Family Members: Please list name(s), alternative address, phone numbers, & email addresses of Family Member(s), as applicable:** _____
  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities:**
  _____
  _____

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**
Address: _____Phone: _____

Email address: _____

☐ **DO NOT RELEASE TO: _____**
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not the patient, please provide name and identify of the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name:_____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to Western Radiation Oncology at their address referenced below. Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

WESTERN RADIATION ONCOLOGY

Text Messaging and Email Messaging Consent Form

Declaration

I consent to Western Radiation Oncology Staff and Provider's contacting me by text message or email for the purpose of appointment reminders.

I acknowledge that appointment reminders by text or email are an additional service, and that the responsibility of attending or cancelling appointments still rests with me. I can cancel the text or email reminders at any time.

Texts or emails are generated using a secure facility. I understand that they are transmitting over a public network onto a persona device that may not be secure. However, the practice will not transmit any information that would enable an individual patient to be identified.

I agree to advise Western Radiation Oncology staff if my mobile number or email changes or if it is no longer in my possession.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Home Telephone Number: _____

Mobile Telephone Number _____

Email Address _____

Western Radiation Oncology does not share mobile phone contact details or email addresses with any external organizations.

☐ I DO NOT CONSENT TO WESTERN RADIATION ONCOLOGY CONTACTING ME BY TEXT OF EMAIL.