STUART ONCOLOGY
ASSOCIATES. P.A.

Prashant R. Patel, MD
Christine G. Simone, MD
Sanjiv Walia, MD

Ravi Patel, MD
Joseph My, DO
Calvin Abro, MD

Please provide ALL information requested

NEW PATIENT INFORMATION

Name:_____
Last First MI

Date of Birth: _____Sex: Female / Male Marital Status: _____ SSN: _____

Address_____ City_____ ST_____ Zip_____

Home Phone: _____Cell Phone:_____

Email: _____

Emergency Contact: _____
Name Phone Number Relationship

RACE: [ ]American Indian [ ]Asian[ ] African American[ ] Caucasian[ ] Hawaiian Pacific [ ]Other

ETHNICITY: [ ]Hispanic [ ]Non-Hispanic[ ]Prefer Not Answer Preferred Language: _____

Are you currently in a Nursing home? Nursing home name _____

Do you have a current DNR? Yes/No do you have a living will? Yes/No **Primary Care Physician:** _____

Referring Physician:_____ **Which doctor are you seeing today?**_____

PRIMARY INSURANCE COMPANYNAME:_____ID#:_____Group#:_____

Work Phone Employer_____

Name of Insured as it appears on card_____Sex_____

Relation to patient_____ Card Holder SSN_____ Card Holder Birthdate_____

SECONDARY INSURANCE COMPANY NAME:_____ ID#_____ Group#_____

Work Phone Employer_____

Name of Insured as it appears on card: _____ Sex: _____

Relation to patient _____Card Holder SSN_____Card Holder Birthdate_____

ASSIGNMENT AND RELEASE

I authorize the release of my medical information needed to process insurance claims. I assign medical/surgical benefits to include major medical benefits including Medicare, government insurance, private insurance, and any other health care plans to Stuart Oncology Associates, PA except for the amount paid by me. This authorization will be for lifetime unless revoked in writing. A photocopy of this is To be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance unless I am a Medicare patient and therefore responsible for 20% of what Medicare allows. My responsibilities include non-covered Medicare/insurance procedures and/or charges.

Signature Date_____

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New Patient Medication Form

Name_____ Date of Birth: _____

Allergies: List all medication allergies

MedicationReaction: _____

MedicationReaction: _____

MedicationReaction: _____

[ ]Iodine [ ]Latex [ ]Shellfish [ ]CT Scan Dye / IV Contrast [ ]Eggs [ ]Peanuts

Pharmacy

Pharmacy Ph#

_____

Address City_____

Retrieving Medication History

Retrieving patient's medication history requires patient's consent.

Please sign and date: _____

List all medications (including non-prescription) that you are currently taking.

Medication	Dose Frequency	Ordering Physician

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HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATIONS & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTOR / TREATMENT FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** Patient name | Please ***sign*** Patient name

_____ _____

Legal Representative | Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes and any care takers, step parents, grandparents who can have access to this patient's records):

Name: _____

Phone: _____ *Relationship:* _____

Name: _____

Phone: _____ *Relationship:* _____

Name: _____

Phone: _____ *Relationship:* _____

I AUTHORIZE CONTACT TO CONFIRM MY APPOINTMENTS, TREATMENTS, LABS OR INJECTIONS VIA:

❑Cell Phone Confirmation
❑Text Message to my Cell Phone
❑Home Phone Confirmation
❑**Any of the above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize. I request that all my protected health information be disclosed only to me and no other family or friends. I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

PatientPrint Name: _____

Patient's Signature: _____ Date: _____

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Patient Financial Responsibility Form

Dear Patient,

Thank you for choosing Stuart Oncology Associates, P.A.as your health care provider. We are committed to providing you with quality health care. Occasionally patients have questions regarding patient and insurance responsibility for services they receive. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). **Please read the policy and sign at the bottom**. **A copy will be provided to you upon request. If you have questions, please let us know.**

Insurance. Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

1. The patient (or patient's guardian, power of attorney) is ultimately responsible for the payment of treatment and care.
2. Patients are responsible for payment of co pays, coinsurance, deductibles, and any non-covered treatment and services not paid for by your insurance.
3. If you fail to provide us with the correct insurance information in a timely manner you will be billed for all insured charges.
4. Your insurance may need certain information directly from you. It is your responsibility to comply with their request.
5. Stuart Oncology will attempt to bill your insurance company twice in an effort to collect payment. In the event your insurance does not pay for billed services the balance will be your responsibility.
6. HMO insurance companies require a referral it is the patient's responsibility to ensure that a current and valid referral is obtained.
7. Missed appointments -there may be a 40.00 fee for appointments not cancelled more than 24 hours in advance. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "noncompliance."
8. Financial Agreement- I understand that my insurance contract is between me and my insurance company. I also agreethatIamresponsibleforanychargesthatmyinsurancecompanywillnotcover.Iunderstandthatfailuretopay my account or make suitable financial arrangements may result in my account being turned over to an outside collection agency. If this becomes necessary, I agree to pay all collection fees which include but are not limited to collection agency fees, court fees, attorney fees, and any other fees for the collection of my account balance. Further, I consent to Stuart Oncology Associates, P.A. inquiries into my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

If foundation is available for your medication, would you like Stuart Oncology to sign on your behalf? Yes _____No____

Signature Date_____

Spouse/ Guarantor Date_____

Witness Date_____

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HIPAA COMPLIANCE AUTHORIZATION FOR USE OR DISCLOUSURE OF INFORMATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release information may no longer be protected by federal privacy regulations.

Stuart Oncology Associates, P.A.

433 SE Ocean Blvd
Stuart, FL 34994
Phone (772) 276-7242
Fax (772) 237-3109

1780 SE Hill moor Drive
Port St Lucie, FL 34952
Phone (772) 807-6525
Fax (772) 807-6526

1231 North Lawn wood Cir
Fort Pierce, FL 34950
Phone (772) 807-652
Fax (772) 807-6526

451 SW Bethany Dr Suite 100
Port St Lucie, FL 34986
Phone (772) 204-0795
Fax (772) 204-0796

Patient's Name (PLEASE PRINT): _____

D.O.B.: _____ Last Four Digits of SSN: _____

Patient's Signature: _____

How Records to be Sent – OFFICE USE ONLY

Reason for Request of Records

_____ **Request of Individual** _____ **Insurance Purposes** _____ **Continuity of Care**

_____ **Legal Action** _____ **other (must describe)** _____

Request Authorized by: _____

(Physician's Signature)

Pick up Date//Patient's Signature_____(At Time of Pick Up)

Fax# Date//Employee Signature_____

Mail Date//Employee Signature_____

Email Date//Employee Signature_____