

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

STUART ONCOLOGY
ASSOCIATES, P. A.

Joseph My, DO
Ravi Patel, 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 COMPANY NAME: _____

ID# _____ Group Control # _____ Copayment _____

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 Control # _____ Copayment _____

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 Medicaid 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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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: _____

Name: _____

Phone: _____ Relationship: _____

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

- Cell Phone Confirmation
- Home Phone Confirmation
- Text Message to my Cell Phone
- 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.

Patient Print 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 copays, 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 agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay 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.

Signature _____ Date _____

Spouse/Guarantor _____ Date _____

Witness _____ Date _____

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HIPAA COMPLAINT AUTHORIZATION FOR USE OR DISCLOSURE 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

9955 SE Federal Hwy
Suite A
Hobe Sound
Phone (772) 444-0345
Fax (772) 934-7305

1780 SE Hillmoor Drive
Port St Lucie, FL 34952
Phone (772) 807-6525
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: _____

Reason for Request of Records

_____ **Request of Individual** _____ **Insurance Purposes** _____ **Continuity of Care**
_____ **Legal Action** _____ **Other (must describe)** _____

How Records to be Sent – OFFICE USE ONLY

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 _____