Osceola Cancer Center, PA

PATIENT INFORMATION – **Please Print** **ACCOUNT NUMBER:** _____

Last Name:	First Name:	Middle Initial:	Date of Birth: / /
Street Address:	Apartment #:	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	E-mail:
Best way to contact you: (Circle) HOME / CELL / WORK / E-MAIL	Social Security #: - -	Driver's License Number:	Age:	Sex: (Circle) MALE FEMALE
Employed: (Circle) YES / NO / STUDENT	Occupation:	Name of Employer:	Employer Phone Number: ( )
Race and Ethnicity: (Circle) Black / White / White Hispanic / Black Hispanic Asian OR Pacific Islander / American Indian / Eskimo / Aleut / Other: _____	Marital Status: (Circle) MARRIED / SINGLE / DIVORCED / WIDOWED	Spouse/Partner Full Name:

EMERGENCY INFORMATION – **Please Print**

Name of contact person **NOT** living in your household:	Relationship:	Phone: ( )
Street Address:	City/State/Zip:

REFERRAL INFORMATION – **Please Print**

How did you hear about us: (Circle) FAMILY / FRIEND / ADVERTISEMENT / INTERNET / INSURANCE CO. / OTHER	Referred by:
Who is your Primary Care Physician:	Primary Care Physician Phone Number: ( )

HIPPA RELEASE: **Please READ – SIGN – DATE**

I acknowledge and agree that Osceola Cancer Center, PA may disclose my protected health information and condition, medical records, and financial information to the following individuals who are family members, friends, legal representatives, power of attorney, or any other on my behalf: *(At any time you have the right to revoke this consent)*

Full name:	Relationship to patient:	Revoke Date if any: / /
Full name:	Relationship to patient:	Revoke Date if any: / /

Do **NOT** release my protected health records pertaining to: *(Please initial all that may apply)*

____HIV/Aids _____Mental Health _____Drug and/or Alcohol Abuse _____Genetic Counseling/Testing

I expressly consent to the release of information as set forth above unless otherwise required by law.

_____ _____ _____

Patient Signature ***Date*** **Office Use Only**

PATIENT INFORMATION – **Please print** **ACCOUNT NUMBER:** _____

Last Name:	First Name:	Middle Initial:

PRIMARY INSURANCE COVERAGE INFORMATION – **Please print**

Primary Insurance Company:	Member ID#:	Member Group name or #:	Are you the policy holder?: YES NO (If "YES" skip to next section)
Patient's relationship to policy holder (circle) SELF SPOUSE CHILD OTHER	Policy holder's date of birth: / /	Policy holder's sex: (circle) MALE FEMALE	Policy holder's Employer:
Policy holder's last name:	Policy holder's first name:	Policy holder's street address:	Policy holder's city/state/zip:

SECONDARY INSURANCE COVERAGE INFORMATION – **Please print**

Secondary Insurance Company:	Member ID#:	Member Group name or #:	Are you the policy holder?: YES NO (If "YES" skip to next section)
Patient's relationship to policy holder (circle) SELF SPOUSE CHILD OTHER	Policy holder's date of birth: / /	Policy holder's sex: (circle) MALE FEMALE	Policy holder's Employer:
Policy holder's last name:	Policy holder's first name:	Policy holder's street address:	Policy holder's city/state/zip:

CONSENT FOR BENEFIT ASSIGNMENT AND RELEASE:

I hereby authorize and direct my insurance carrier(s) to issue payment directly to Osceola Cancer Center, PA for medical service rendered to myself and/or dependant/s regardless of my insurance benefits. I understand that I am responsible for any financial responsibilities that are not covered by my insurance plan. This consent is also to release any information (including the release of HIV/Aids, Mental Health, Substance Abuse and any communicable diseases); this form, forms and/or records of other organizations, hospitals, physicians, dentists, or pharmacies regarding my condition and care, to my insurance carrier(s) in order to support my claim for medical necessity and continuity of care.

I assign payment directly to Osceola Cancer Center which may be due from my insurance/s listed above. If additional information is needed to support my claim, I hereby release all protected medical records to my insurance/s listed above.

_____ _____

Patient Signature ***Date***

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT:

Osceola Cancer Center's Notice of Privacy Practices provides information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices prior to signing this form. As stated in the Notice, the terms may change at any time in which you can receive a revised copy upon contacting our office. You have the right to request that we restrict how information about you is used or disclosed. However, we are not required to agree. By signing this form, you consent to our use and disclosure of your protected healthcare information for treatment, payment, and other healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except in cases which we have already made releases based on your prior consent.

I have read and understand Osceola Cancer Center's Notice of Privacy Practices

_____ _____ _____

Patient Signature ***Date*** **Office Use Only**

PATIENT INFORMATION – **Please print** **ACCOUNT NUMBER:** _____

Last Name:	First Name:	Middle Initial:

PHARMACY INFORMATION – **Please print**

Do you have a prescription drug plan: (circle) YES NO	Prescription drug plan name:	Prescription drug plan phone number:
What is the name of the local pharmacy you use most:		Local pharmacy phone number:
Local pharmacy street address:	Local pharmacy City/State/Zip:	

LIST OF CURRENT MEDICATIONS – **Please print**

Medication Name	**Dosage**	**Frequency**	**Who Prescribed?**

LIST OF **CURRENT** PHYSICIANS YOU SEE – **Please print**

Physician Name	**Physicians Specialty**	**Physicians Phone Number**

AUTHORIZATION FOR TREATMENT:

I authorize Osceola Cancer Center, PA to provide whatever treatment they deem necessary to the patient listed above. This authorization does not expire. I certify that all the information provided by me or my legal representative today is true and correct.

_____ _____ _____

Patient Signature ***Date*** **Office Use Only**

Osceola Cancer Center, PA

737 W. Oak Street Kissimmee, FL 34741
PH: (407) 933-2775
FAX: (407) 847 - 4351

Authorization to obtain or release Protected Health Information

I, _____ hereby voluntarily authorize Osceola Cancer Center, PA to:
Print patient name OR name of LEGAL representative

☐ **OBTAIN** individually protected health information and medical records listed below in order to carry out treatment, payment or healthcare operations.

☐ **RELEASE** individually protected health information and medical records listed below for the following purpose of: (EXPLAIN or mark item/s below)_____

☐ ***Legal request*** ☐ ***Moving out of area*** ☐ ***Continuation OR Transfer of care*** ☐ ***Insurance***

I understand that I may select the information from the list below to be obtained or released by placing my initials in the space provided. This authorization is revocable upon written notice to the office where the original authorization is retained, unless records have already been released prior to the written notice.

_____ Complete records	_____All diagnostic test results	_____Pathology reports
_____ Consultation	_____ Lab results	_____Therapy records
_____ Progress notes	_____ Operative reports	_____ Radiology
_____ Other: (Please specify)_____		

In addition to the above information, I also authorize the following information to be obtained or released:

_____Mental health	_____HIV testing	_____Genetic testing
_____Drug and/or alcohol	_____AIDS information	

PATIENT INFORMATION – **Please Print**

Last Name:	First Name:	Middle Initial:	Date of Birth: / /
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Social Security #: - -

PERSON OR FACILITY TO OBTAIN OR RELEASE MY PROTECTED HEALTH INFORMATION:

Name of Person or Facility:	Phone Number: ( )	FROM Date of Service: / /	TO Date of Service: / /

Street Address:	Apt. OR Suite #:	City:	State:	Zip:

I am the patient or legal authorized representative of the patient requesting Osceola Cancer Center, PA to obtain or release the requested protected health information listed above. I understand that this authorization is good for one year from the date signed but may be revoked at any time as mentioned above. I have read fully and understand this consent.

_____ _____ _____
Signature ***Date*** **Office Use Only**