



**We Appreciate the Opportunity of Serving you. We Pledge to Give you Our Best Medical Care.**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PLEASE CHOOSE WHICH NUMBER(S) WE MAY LEASE MESSAGES AT:  HOME  CELL  WORK

MARITAL STATUS:  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DATE OF BIRTH: \_\_\_\_\_

INSURANCE ID: \_\_\_\_\_

POLICY HOLDER RELATIONSHIP TO YOU:  SELF  SPOUSE  PARENT  
 OTHER \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DATE OF BIRTH: \_\_\_\_\_

INSURANCE ID: \_\_\_\_\_

POLICY HOLDER RELATIONSHIP TO YOU:  SELF  SPOUSE  PARENT





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**Release of Information**

Many of our patients allow family members such as their spouse, significant other, parent or children to call and request the patient's medical information. Under the requirements for H.I.P.A.A we do not have permission to give this information to anyone without the patient's signed consent. If you wish to have your medical information released to any family members you must sign this form.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Other: \_\_\_\_\_

Medical information may not be released to anyone

**Messages**

The best time to reach me is (day) \_\_\_\_\_ between(time) \_\_\_\_\_

If unable to reach me:

You may leave a detailed message

Leave only a message requesting a call back

Other \_\_\_\_\_

**This release of information will remain in effect until terminated by me in writing.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Consent for Release of Healthcare Information Form**

I authorize the Doctor to release any medical information including diagnosis, radiology results, laboratory results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of this information.

Patient name: \_\_\_\_\_

Previous name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ social security number: \_\_\_\_\_

I authorize and request \_\_\_\_\_ to release healthcare information of the patient named above to:

**Northern Virginia Hematology and Oncology Associates**

The request and authorization apply to:

Healthcare information relating to the following treatments, conditions, or dates:

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**This release of information will remain in effect until terminated by me in writing.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Office Policy on Payments and Insurance

### Office Payment Policy

It is our policy to require payment for all office charges at the time services are rendered, unless prior arrangements have been made.

- All accounts over **60 days** past due will be assessed an interest charge of **1.5% per month** (18% per annum) or a **\$2.00 minimum**, whichever is greater.
- In the event that a balance is not paid as agreed, the undersigned **jointly and severally agree** to pay all fees assessed by a collection agency (not to exceed 20% of the unpaid balance), including reasonable attorney's fees.
- **New patients** will be charged a **\$25.00 rescheduling fee** if the office is not notified of a cancellation **at least 24 hours** prior to the scheduled appointment.

### Insurance Policy

Insurance is a contract between you and your insurance carrier for reimbursement of allowed medical charges.

As a **courtesy**, we will:

- Provide you with an **itemized statement** to submit to your insurance company, **or**
- **Submit claims** to most insurance carriers **if** you provide us with:
  - o Policy numbers
  - o Insurance company address
  - o Employer information
  - o Any other required details

Please note:

- You are **responsible** for all **deductibles, copayments**, and any charges **not covered** by your insurance.
- We **cannot act as a third party** in extended insurance negotiations. Any follow-up with your insurance is **your responsibility**.

### Authorization and Acknowledgment

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. This authorization may be **revoked in writing** by either myself or my insurance company at any time.

I have read and understand the above policy and accept **full financial responsibility** for my account.

**Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_