SAND LAKE
CANCER
CENTER
A PLACE OF HOPE AND HEALING

New Patient Packet

Patient Name: ______________________________ Date of Birth: ____________ Sex: ________
Social Security: ____ Marital Status: M/S/W/D
Race: _____________________________ Ethnicity: _________________________ Smoker: Yes/No
Address: ____
City: ______________________________ State: _______________ Zip Code: ________________
Cell Phone: ___________________________ Alternate Phone:_____________________________
Employer: _____________________________ Occupation: _______________________________
Work Phone: ______________________
Email: ____
Name of spouse/parent/guardian: ____________________ Spouse Date of Birth: __________
Spouse Social Security: ____________________ Spouse Phone Number: ___________________
Person *(who does not live with you)* to contact in case of emergency: ________________
Emergency Contact Phone Number: ____

Primary Care Physician: ___________________________ Phone Number: ___________________
Referring Physician: _______________________________ Phone Number: ___________________
Preferred Pharmacy: ______________________________ Phone Number: __________________
Address: ____
Hospital Preference: ____

<u>Payment Information</u>

In order to control our billing costs, we request that any payments for office visits be paid before each visit. If you are a member of a HMO or PPO it is your responsibility to bring your referral form.

<u>Insurance, Authorization, Assignment and Information Release</u>

I hereby authorize my physician to furnish information to insurance carriers and physicians concerning my illness and treatment and I hereby assign to the physician(s) all payments of medical services rendered to myself and my dependants. I understand that I am responsible for any amount not covered by insurance.

Signature: ____
Guarantor's Signature: __________________________________
Date: ______________________

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Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected 'health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except when we have already made disclosure in reliance of your prior consent.

Patient name: ____________________________________

Signature: ____

Date: ____

Witness: ____

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Release and/or Request of Information Authorization Form
7301 Stonerock Circle, Suite 2, Orlando FL 32819
Tax ID 20-3546219

Please fax all records to: ________________________

Full Name: __________________________________ Date of Birth: __________________________

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45CFRfj164.5081. I authorize the Sand Lake Cancer Center, my physician and/or administrative and clinical staff to (check all that apply):

______ Obtain the following protected health information, and/or
______ Release the following protected health information
____

Obtain and/or release my protected health information from/to:
____

Description of information to be obtained or released:
____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at the above address. I understand that a revocation is not effective to the extent that the above named has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information requested or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this Authorization. If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

Signature of Patient or Personal Representative: ______________________________________
Print Name of Patient or Personal Representative: ____________________________________
Description of Personal Representative's Authority: ____________________________________
Date: ______________________

SAND LAKE CANCER CENTER
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Assignment of Benefits

In order for Sand Lake Cancer Center to bill Medicare and/or other insurance for your medical care, please complete, sign and date this form. In consideration of the medical services provided to me, I hereby assign and transfer to Sand Lake Cancer Center, (SLCC), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct my insurance company to pay all such benefits to SLCC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by my insurance company, unless otherwise provided by the terms of an agreement between the insurer and SLCC.

I have read and fully understand the above statement:

Patient name: ___________________________________

Signature: ______________________________________

Date: ____

Witness: ____

SAND LAKE CANCER CENTER

A PLACE OF HOPE AND HEALING

Financial Policy

I fully understand that Sand Lake Cancer Center will file all charges for services rendered to my insurance company. I agree to pay for all non Covered services, Co-pays, Co insurance and deductibles at time of service. It is my responsibility to notify Sand Lake Cancer Center immediately of any changes to my insurance or contact information as address, phone numbers and place of employment. All quotes are an estimate of service and not a guaranty of payment by insurance.

Co payments/Co-Insurance: Initial: ________

I understand co-payments are due at the time of visit and will be collected during check in at the time of my appointment.

Payments: Initial: ________

I understand that in order to avoid finance charges I must pay the balance in my account within 30 days upon the receipt of the first statement.

Finance Charges: Initial: ________

I understand that should I not pay the balance on my account within 30 days upon the receipt of the first statement my account will incur a finance charge of 1% per month.

Payment Arrangements: Initial: ________

I understand payment plans can be pre arranged if necessary as long as I compromise to a down payment of 50% of the total cost of the treatment.

Collections Policy: Initial: ________

I understand that if my account defaults over 90 days with no payments within that time frame it will be referred to a collections agency for further actions.

Collections Debt: Initial: ________

I understand that if my account goes to collections, the collection agency may add a fee of 33% to my debt.

Patient Signature: ____________________ Acct # ______________ Date: ____________

Patient Name: ____

Parent Guardian: ___________________________________

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Cancellation Policy

I fully understand that a charge may be placed on my account if I am to miss an appointment without a **24 hour notice** to the practice. I understand that Sand Lake Cancer Center reserves the right to place a charge on my account for a missed appointment or cancellation within 24 hours of my appointment. A charge will not be made to my account if I am to cancel 24 hours prior to my appointment. I agree that I will call the practice 24 hours prior to notify them if an appointment date and time must be changed or cancelled as to not incur the fee. I understand that if I am unable to call during regular business hours I may leave a message on the answering machine for the office.

By signing below I certify that I have read and understand the cancellation policy and will provide a notice 24 hours prior to the set appointment if there is a need to change or cancel the appointment so that I may not incur any fee.

Patient Signature:_______________________________________Date:__________________
Patient Name:____

Medical Documentation Fees Agreement

I understand that it is the policy of Sand Lake Cancer Center to charge a fee to all patients when if they require a form or letter to be completed by the physician on behalf of the patient.

Type of Document	Cost
☐ FMLA/Disability	$25.00
☐ Handicap Parking Permit	$10.00
☐ Letters	$25.00
☐ Other Forms	$25.00

By signing below I certify that I have read and understand the policy regarding additional documentations I may need, and the charges associated with each.

Patient Signature:_____________________________________Date:__________________
Patient Name:_______________________________________

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. We believe that in the interest of an ongoing mutually satisfying doctor/patient relationship, it is important to clearly state the terms of our service. We request you read and sign the following financial policy prior to treatment. Patients or responsible party must complete our information and insurance form before seeing the physician.

FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD AND AMERICAN EXPRESS.

We realize that your time is valuable and that long delays in the schedule are unacceptable. We do our best to schedule carefully and to confirm appointments when possible. Emergencies do arise in an oncology/hematology practice, but a major cause of scheduling disruption is missed appointments. We do not want to resort to over-booking to cover these '"no shows", so it is urgently important that you cancel/reschedule appointments at least 24 hours in advance.

There is a $35 charge for checks returned for insufficient funds.

The treatment of minors must be authorized by the signature of a parent or guardian on medical history, financial policy, insurance and consent forms prior to treatment. Subsequent charges may be handled by pre-authorized credit card, check or cash.

For insurance office policies, please* read *whichever applies to you:

INSURANCE (NON-PARTICIPATING COMPANIES):
Your insurance policy is a contract between you and your insurance company, **and Sand Lake Cancer Center is not a party to that contract.**

You are responsible for full payment of the charges at the time of service. For your convenience, however, we will file your claim for you and your insurance company will reimburse you directly, based on the specifics of your insurance policy.

Our practice is committed to providing the best treatment for our patients and we charge what we consider appropriate for the expertise involved in your care. You are responsible for payment regardless of any insurance company's arbitrary determination of “allowed" or "usual and customary” rates.

PPO / MEDICARE (PARTICIPATING COMPANIES):
As a participating provider, the contract for service is between the insurance company and Sand Lake Cancer Center. We are contractually required to collect co-payments / percentages / deductibles at the time of service. Please be aware that some of the services provided may be considered by your plan to be "non-covered" or "not medically necessary". Therefore, you will be expected to pay for them at the time of service. If your insurance coverage changes to a plan in which we are not a participating provider, you will be expected to pay in full at the time of service. Patients with an HMO as a secondary insurance need a referral for each visit in order for the secondary insurance to apply, for your convenience we will take it upon ourselves to request that referral for you prior to your visit.

HMO (PARTICIPATING COMPANIES):
As a participating provider, the contract for service is between the insurance company and Sand Lake Cancer Center. We are contractually required to collect co-payments / percentages / deductibles at the time of service.

In order to see a Hematology/Oncology Specialist an HMO plan requires a referral from your primary care physician prior to your appointment(s). In case treatment is necessary, authorizations and referrals might be required as well prior to treatment. We will take it upon ourselves to request the necessary referrals / authorizations prior to your visits. By contract, we are unable to see you without this authorization.

Please be aware that some of the services provided may be considered by your plan to be "non-covered" or "not medically necessary". Therefore, you will be expected to pay for them at the time of service.

If your insurance coverage changes to a plan in which we are not a participating provider, you will be expected to pay in full at the time of service.

I understand and agree to this financial policy: ____

Signature Date