

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

STUART ONCOLOGY
ASSOCIATES, P. A.

Joseph My, DO
Ryan Devine, DO

** Please provide ALL information requested**

NEW PATIENT INFORMATION

Name _____ SSN _____
Last First MI
Address _____ City _____ ST _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____ D.O.B. ____/____/____
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 INFORMATION

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 INFORMATION

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, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Stuart Oncology Associates, PA all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signature _____ Date _____

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New Patient Medication Form

Name _____ Date _____

Date of Birth: _____

Allergies: List all medication allergies

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

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 Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you if used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect and disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act Of 1996 (HIPAA).

The patient understands that:

I authorize Stuart Oncology Associates P.A. to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatric, laboratory studies, HIV testing and other medical data related to my care. I authorize any insurer or payor to make payment directly to Stuart Oncology Associates P.A. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

Protected health information may be disclosed or used for treatment, payment, or health care options.

The practice has a notice of privacy practices and that the patient has the opportunity to review this notice.

The practice reserves the right to change the notice of privacy practices.

The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice may condition receipt of treatment upon the execution of this consent.

Acknowledgement Of Notice Of Privacy Practices

My signature below verifies that I, _____, have received a copy
(Print Name)

of notice of privacy practices from Stuart Oncology Associates P.A.

Signature of Recipient _____ Date ____/____/____

PROTECTED HEALTH INFORMATION AUTHORIZATION (OPTIONAL)

Consent to Disclose Medical Information

Please check one of the following:

I give my permission to the employees of Stuart Oncology Associates P.A. to disclose my protected health information to me and the following family and friends

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

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.

Patient's Signature _____ Date _____

Patient's Printed Name _____

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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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MEDICAL RECORDS RELEASE

Date ____/____/____

**I hereby request that my medical records
be sent to one indicated below, thank you.**

Stuart Oncology Associates, P.A.

501 SE Osceola St
Suite 301
Stuart, FL 34994
Phone (772) 223-5955
Fax (772) 223-5954

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)

Patient's Signature

(Patient's) Address City State Zip

Birthdate ____/____/____ **Last four digits of Social Security #** ____

Reason for Request of Records

For Continuous local care for my diagnosis and for my treatment.

Forward records to referring providers and primary care physicians.

Request Authorized by _____
(Physician's Signature)

How Records to be Sent – OFFICE USE ONLY

Pick up _____ Date ____/____/____ Patient's Signature _____
(At Time of Pick Up)

Fax # _____ Date ____/____/____ Employee Signature _____

Mail _____ Date ____/____/____ Employee Signature _____