Columbus Oncology & Hematology
Serving Ohio Since 1987

Patient Name _____ Date _____

Address _____ City _____ State _____ Zip _____

SSN _____ Birthdate _____ Home # _____

Cell # _____ E-mail Address _____

Preferred method of contact: ☐ home phone ☐ cell phone ☐ e-mail

Race (please select): ☐ White ☐ Hispanic ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Non Latino ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Bosnian ☐ Indian ☐ Sign ☐ Other _____

Employer _____ Position _____

Address _____ Phone # _____

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

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Spouse _____ SSN _____ Birthdate _____

Spouse's Employer _____ Employer Phone # _____

Person to contact in case of an emergency _____ Phone # _____

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Insurance Co.	Insurance Co.
Address	Address
Subscriber	Subscriber
ID #	ID #
Group #	Group #
Effective Date	Effective Date

Referring Physician _____ Family Physician _____

& Phone # _____ & Phone # _____

I authorize Columbus Oncology and Hematology Associates to release to any third party payer, such as an insurance company or government agency, any medical information contained in my records when such material is required in connection with determining a claim for payment.

I authorize Columbus Oncology and Hematology Associates to release any medical information accumulated in the course of my examination or treatment to any other requesting physician, hospital, or nursing home.

I authorize payment directly to Columbus Oncology and Hematology Associates for the surgical and/or medical benefits, if any otherwise payable to me under the terms of my insurance and/or Medicare.

I hereby accept responsibility for payment of services not covered by Medicare or my insurance company.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Date _____ Signature _____
(Patient or Parent if under 18 years of age)

Date _____ Primary Policyholders Signature _____

How did you find out about our practice? _____

Columbus Oncology & Hematology

BILLING POLICY

Thank you for choosing Columbus Oncology and Hematology. Each of our oncologists is board certified, and these dedicated physicians remain on the cutting edge of advances in medical research and technology to offer care that is not only compassionate and personal, but also informed and innovative. For every person who walks through our doors, we believe in providing comprehensive care, and we foster an environment where your questions will be addressed with kindness and promptness. The following information is provided to avoid any misunderstanding concerning payment of services provided by our office.

- Our office participates with a variety of insurance plans. In order to verify we are in-network with your specific plan, it is best to contact them directly.
- Please bring your current insurance card(s) to every visit and notify us of any changes in coverage.
- You will be responsible to obtain a referral to our office, if your insurance plan requires such.
- Copays not paid at the time of service, will be assessed a billing fee of **$35.00**.
- COHA will verify eligibility with your payer, and obtain required prior authorization, before starting treatment. If we are unable to verify eligibility or obtain prior authorization, we will notify you prior to beginning treatment.
- Treatment estimates will be communicated to patients before starting treatment, along with pre-payment deposit requirements.
- With consent, COHA will determine if Patient Assistance funds are available, before starting treatment.
- We will submit your claim for you, as long as we receive accurate and complete billing information.
- We accept assignment on Medicare claims; therefore, the twenty percent of Medicare's approved amount is considered patient responsibility, along with any remaining deductible.
- We will make every attempt to notify you when a service may not be covered; however, it is not possible for us to always know when the insurance company may disallow payment as non-covered or not medically necessary. Ultimately, you are financially responsible for payment of services.
- For those patients with no insurance, payment in full is required at the time of service.
- Patients may request an itemized bill of services at any time.
- Statements will be issued for outstanding account balances totaling **$5.00** or more.
- Small Balance Policy
    - Total patient account balances between **$.01 - $4.99** are considered small balance, and will be adjusted to small balance, as they do not meet the minimum statement threshold for processing.
    - Total patient account balances between (**$.01) – ($4.99)** are considered small balance credits and will be adjusted to small balance, and not processed for refund.
- All patient balances are considered due in full, unless a payment contract has been established with the billing office.
- Unpaid balances are reviewed and may result in placement with our collection agency, PCB Rossman.
- All returned checks will be assessed a service fee in the amount of **$35.00**.
- Medical records will be provided to a patient free of charge, as a one-time courtesy. Additional requests or authorized third party requests, will incur fees for copying records, as outlined in ORC Section 3701.741.

Patient's Name_____ Date_____

Signature of Patient or Responsible Party_____