Columbus Oncology and Hematology Associates

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? _____

BILLING POLICY

Columbus Oncology and Hematology Associates

Medical Care and treatment can be expensive and insurance delays frustrating. To reduce these burdens, we have developed several important policies.

- We will submit your claim for you, if you will provide accurate, complete information. As a courtesy, we will refile the claim one time. YOU MUST BE AWARE, THOUGH, THAT THE ULTIMATE RESPONSIBILITY FOR YOUR FINANCIAL OBLIGATION LIES WITH YOU, AND THE CLAIM NEEDS TO BE PAID WITHIN NINETY DAYS.

  (WE ACCEPT ASSIGNMENT ON **MEDICARE** CLAIMS, THEREFORE THE TWENTY PERCENT OF MEDICARE'S APPROVED AMOUNT IS THE PATIENT'S RESPONSIBILITY AND IS DUE WITHIN NINETY DAYS OF THE MEDICARE PAYMENT.)

- For those patients with no insurance or who choose to file their claims on their own, we ask that charges resulting from office visits and medical attention be paid in full at the time of service.

- All patients will be provided with an itemized bill of services rendered and charges accrued, either at the time of payment or in a monthly statement that can be used for additional insurance you might have.

- All balances are considered due in full immediately, unless a payment contract has been established with the billing office.

- We will file secondary insurance one time as a courtesy. We will not file claims to more than a total of two insurance carriers.

- **COPAYS ARE TO BE PAID AT EACH VISIT AT THE TIME OF SIGN-IN. IF WE MUST BILL YOU FOR COPAY, A $35.00 BILLING FEE WILL BE ADDED TO YOUR STATEMENT.**

Signature _____ Date _____

(Patient or Parent if under 18 years of age)