NEW PATIENT FORM

Today's Date:_____

(Please print. Thank you.)

Patient Name:_____

DOB:_____/_____/_____Age_____Male_____ Female_____ SSN:_____

Address:_____ Phone: (_____) _____

Cell Phone: (_____) _____

City:_____State:_____Zip:_____

Secondary Address: _____

City:_____State:_____Zip:_____

May we leave a message on your answering machine / voicemail? ____Yes ____No

Email Address:_____May we email you? ____Yes ____ No

Preferred Language:_____

Disclaimer: Any section left blank in Ethnicity/Race, Sexual orientation, Gender identity, Sex Assigned at Birth, and Disability status will automatically be assumed as you choose not to disclose this information.

Ethnicity/Race:_____White_____Hispanic/Latino_____Black/African American_____Native American_____Asian/Pacific Islander____Other_____

☐ I prefer not to disclose my Gender Identity, my Sexual orientation, and my Disability Status

Sex Assigned at birth: ___ Male ___ Female ___ Unknown

Sexual Orientation: ____ Lesbian, gay or homosexual ___ Straight or heterosexual ___ Bisexual ___Don't know

Gender Identity: ___Male ___Female ___ Female-to-Male (FTM)/Transgender Male ___Male-to-Female (MTF)/Transgender Female ___ Genderqueer, neither exclusively male nor female ___ Unknown ___ Additional gender category or other please specify_____

Disability Status:

No Disability ____

Are you blind, or do you have serious difficulty seeing, even when wearing glasses? ___Yes ___No ____Unknown ____ Asked but declined.

Are you deaf, or do you have serious difficulty hearing? ___Yes ___No ____Unknown ____ Asked but declined.

Because of a physical, mental, or emotional condition, do you have a serious difficulty concentrating, remembering, or making decisions? ___Yes ___No ____Unknown ____ Asked but declined.

Do you have difficulty dressing or being bathed? ___Yes ___No ____Unknown ____ Asked but declined.

Do you have serious difficulty walking or climbing stairs? ___Yes ___No ____Unknown ____ Asked but declined.

Because of a physical, mental, or emotional condition, do you have difficulty doing errand alone such as visiting a doctor's office or shopping? ___Yes ___No ____Unknown ____ Asked but declined.

PHYSICIAN	NAME	ADDRESS	PHONE
Primary Care Physician			
Referring Physician (if different)			
Other Physician			
Other Physician			
Other Physician			
Other Physician			

Emergency Contact Name:_____

Relationship:_____ Phone: (_____) _____

Durable Medical Power of Attorney (if applicable):_____Yes* _____No *Please provide a copy for your records.

Relationship to you:_____

Living Will: _____ Yes* _____ No *Please provide a copy for your records.

DNR: _____ Yes* _____ No *Please provide a copy for your records.

RCCA
REGIONAL CANCER CARE ASSOCIATES LLC

NEW PATIENT FORM

Patient Name: _____DOB:_____/_____/_____

Primary Insurance Carrier

Name of primary policyholder:_____

Name of insurance company:_____ Policy Number:_____

Policyholder's Date of Birth:_____ Policyholder's SS#:_____

Policyholder's employer:_____

Policyholder's employer address:_____

Policyholder's employer phone #:_____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier

Name of secondary policyholder:_____

Name of insurance company:_____ Policy Number:_____

Policyholder's Date of Birth:_____ Policyholder's SS#:_____

Policyholder's employer: _____

Policyholder's employer address:_____

Policyholder's employer phone #:_____

Does plan have prescription coverage? ☐ Yes ☐ No

Where did you learn about RCCA?

☐ Physician Referral ☐ Family / Friends ☐ Insurer

☐ Advertisement ☐ Internet Search ☐ RCCA Website

I certify that the information I have given today is to the best of my ability as fully and as accurately as possible. I will notify the doctor/staff of any changes or additions at subsequent visits.

Signature: _____Date: _____

Print Name: _____

GENERAL CONSENT FOR RCCA SERVICES

Patient Name: _____DOB:____/_____/_____

At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical, or diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved. This consent provides us with your permission to perform reasonable and necessary medical services (examinations, testing and treatment) in person or remotely by phone, video, text messages and via the internet. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent is for all necessary services including evaluation and management in the office, via phone or video consultations and in other facilities you may be admitted/treated to/at from time to time, chronic and principal care management, transition of care management discussions, and other necessary services and will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

- I consent to the necessary treatment and diagnostic tests my physician orders for my care.

- I authorize the release of all medical records to the referring, consulting and family physicians and to my insurance company, if applicable.

- I allow fax transmittal of my medical records, if necessary.

- I acknowledge responsibility for services rendered by Regional Cancer Care Associates LLC or Regional Cancer Care Associates MD LLC

- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Co-pays are due at the time of service per your health insurance policy.

- I further authorize and request that insurance payments be made directly to Regional Cancer Care Associates LLC should they elect to receive such payment.

- I have received information and a copy of Advance Directives Documents and will discuss this with my physician; I may also ask for a copy from the receptionist at appointment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, INSURANCE AUTHORIZATION AND INFORMATION AND DOCUMENTS ON ADVANCED DIRECTIVES.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

NOTICE TO PATIENTS REGARDING CO-PAYS

To eliminate any confusion regarding co-pays and your responsibilities as our patient, please read the following:

- Co-pays are due at the time of service; we are required to collect your co-pay if your insurance states you have one.
- We accept cash, checks, and credit cards.
- We do not "bill you" for your co-pays, it is expected that co-pays be paid at the time you are seen in the office.
- Your health insurance plan deducts your co-payment from the payment they send us in expectation that we collect your co-pay.
- We are in violation of our contract with your health insurance plan if we do not collect your co-pay.

Co-pays apply when you see the physician, APRN or PA. They may apply when you see the nurse.

- Any questions regarding your co-pay or insurance questions should always be directed to our Business Office