



**Request for Confidential Communications**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please indicate the methods of contact and appropriate numbers you authorize us to use in order to reach you: (Check and complete all that apply.)

<input type="checkbox"/> Home Number _____	<input type="checkbox"/> Work Number _____
<input type="checkbox"/> Cell Number _____	<input type="checkbox"/> Fax Number _____
<input type="checkbox"/> Email Address _____	
<input type="checkbox"/> Other _____	<input type="checkbox"/> It is ok to leave a message if I can't be reached.

**Emergency and HIPPA Contact Information**

In our effort to adhere to HIPPA guidelines, NexGen Oncology needs your authorization to release information connected with your care to your family members, friends, or other designated persons. We also need to identify persons' we may contact on your behalf in the event of an emergency. Please indicate your emergency contacts below and to whom we may release information.

- Do not discuss any of my confidential information with anyone other than myself.
- Release information to the following people as necessary.

Primary Emergency Contact Name: \_\_\_\_\_  
 Relationship to me: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Type of Information that we can provide them: \_\_ Medical \_\_ Financial \_\_Both \_\_Neither

Secondary Emergency Contact Name: \_\_\_\_\_  
 Relationship to me: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Type of Information that we can provide them: \_\_ Medical \_\_ Financial \_\_Both \_\_Neither

Other Contact Name: \_\_\_\_\_  
 Relationship to me: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Type of Information that we can provide them: \_\_ Medical \_\_ Financial \_\_Both \_\_Neither

**Acknowledgement of Receipt of Notice of Privacy Practices and Consent for Professional Services**

I acknowledge that I have been presented with a copy of NexGen Oncology's Notice of Privacy Practices. I understand that it explains how my medical information will be used and disclosed as well as my rights pertaining to the use and disclosure of my health information. I consent to treatment/services necessary for the care of my present medical condition. I authorize holder of medical or other information about me to release information needed to determine benefits.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority



## NexGen Oncology Financial Policy

1. Payment is due at time of service unless arrangements have been made in advance by you or your insurance carrier. We accept cash, personal checks, Visa, MasterCard, and Discover.
2. As a service to you, NexGen Oncology will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, you are responsible for remitting payment.
3. Our practice has made prior arrangements with many insurance companies and other health plans to accept as assignment of benefits. We will bill them and you are required to pay any co-payment, co-insurance, and/or deductible at the time of your visit. As dictated by the terms of our contracts with insurers, we cannot waive any co-payments, co-insurance, and/or deductible.
4. Secondary insurance filing will be determined on a case by case basis.
5. If you do not have insurance, payment arrangement must be made prior to service. If you first saw the Physician in the hospital, payment arrangement must be made immediately after hospital discharge.
6. Medicare: We accept assignment on Medicare claims. You are required to pay your 20% co-insurance and deductible at the time of service unless we have verified with Medicare that your deductible has been met.
7. Patient Responsibility: you will be billed for services designated by your insurance company as patient responsibility. Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.
8. If there are any changes to your insurance during or throughout the year, it is your responsibility to notify NexGen Oncology.
9. I hereby assign, transfer and set over to NexGen Oncology my assignment of benefits for reimbursement of services rendered.

This consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

_____ Patient Signature	_____ Date
_____ Printed Name of Personal Representative	_____ Description of Personal Representative's Authority