cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

WELCOME TO cCARE!

SAN DIEGO LOCATIONS:
4S RANCH
16918 Dove Canyon Rd
Suite 103
San Diego, CA 92127
Ph: 858.649.5100
Fax: 858.649.5099

ENCINITAS
326 Santa Fe Drive
Suite 105
Encinitas, CA 92024
Ph: 760.452.3340
Fax: 760.452.3344

LA JOLLA
9850 Genesee Ave
Suite 560
La Jolla, CA 92037
Cancer Center
Ph: 858.552.1410
Fax: 858.552.0929
Neurosurgery
Ph: 858.909.9033
Fax: 858.429.4009

MURRIETA
25405 Hancock Ave
Suite 206
Murrieta, CA 92562
Ph: 760.733.9191
Fax: 760.733.9192

SAN MARCOS
838 Nordahl Road
Suite 300
San Marcos, CA 92069
Ph: 760.747.8935
Fax: 760.747.7951

FRESNO LOCATION:
FRESNO
7130 N. Millbrook Ave
Fresno, CA 93720
Ph: 559.326.1222
Fax: 559.447.4925

California Cancer Associates for Research and Excellence (cCARE) is the largest full-service, private oncology and hematology practice in California.

With offices in San Diego and Fresno, cCARE offers extensive services and world-class care for every step of your treatment including: oncology, chemotherapy, radiation oncology, hematology, infusion and imaging.

At cCARE we believe that treatment is more than just medicine. It's about compassion, prevention, research and wellness. We know that cancer treatment requires medical intervention, but it is also our belief that a strong will and a solid support group will play vital roles in the healing process. That is why our expert team of board-certified oncologists, hematologists, nurses and other highly-skilled cancer care professionals all work together closely with our patients and their loved ones throughout the course of recovery. It is this compassionate approach, combined with our state-of-the art facilities, comfortable environment and commitment to utilizing the most advanced treatment techniques available that help make cCARE California's premier oncology center.

For your first visit, please complete and sign all forms. You will need to present these forms to the front desk when they are complete.

If you need to reschedule or cancel your new patient appointment, **please call 858.753.6446 at least 24 hours before your visit.**

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available.

We accept most insurance carriers and our staff will work with you before you come for your initial appointment to ensure that you have the coverage you will need. If you have a managed care plan that requires a referral from your primary care physician, please ensure that you have obtained that referral as it is the patient's responsibility to do so. Referrals occasionally have limits on the number of visits which patients may be allowed and/or an expiration date. Please monitor this information and obtain updated referrals as required. **Co-payments, deductibles and non-insurance covered medical services are due at the time of the service.**

WE ASK THAT PATIENTS ALWAYS:

- Bring insurance cards to each visit. **If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure that we have all information. Please make sure to bring all your cards.**
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over the-counter medications currently taken. Please bring your prescription card. Some patients find it more convenient to bring the medication bottles to the appointment. Note that over the counter drugs include vitamins, herbs, aspirin, Tylenol, etc.
- Allow a 48-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- **Consider the compromised immune systems of other patients, and refrain from bringing children to your appointments.**
- Write down any questions or concerns that arise to discuss with the physician.

Once a patient has made an appointment, all facets of our services-from the latest research findings to the most advanced technology-will be utilized in providing the highest level of quality medical care. Please complete the patient registration forms **BEFORE** your appointment.

Again, we welcome you and say thank you for choosing our practice. For further information, please visit our website at cCARE.com and should you need additional assistance, please call:

- San Diego - New Patient Department: 858.753.6446
- Fresno - New Patient Department: 559.326.1905

MRN:

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Today's Date: ____________________

Patient Name: ____

DOB: ____/____ /____ Age: ____ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: ________________________ Cell Phone: (______) ______________ Phone: (______) ______________

Address: ____

City: ____ State: ____________ Zip Code: _________________

Secondary Address: ____

City: ____ State: ____________ Zip Code: _________________

May we leave a message on your answering machine / voicemail? ☐ Yes ☐ No

May we send appointment reminder via text? ☐ Yes ☐ No Cell Phone: ______________________ (If not already provided)

Email Address: _______________________________________ May we email you? ☐ Yes ☐ No

Preferred Language: ____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American
☐ Asian/Pacific Islander ☐ Other

Occupation: ____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _______________________________________ Work Phone: (______) _______________

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home
☐ Winter Resident ☐ Year Round Resident

Children: ☐ Yes ☐ No If yes, how many? _________________

Primary Care Physician: ______________________________ Phone#: _______________________________

Referring Physician (if different): _____________________ Phone#: _______________________________

Please list any additional physicians you see: (Include Phone#):

____ Phone#: _______________________________

____ Phone#: _______________________________

____ Phone#: _______________________________

____ Phone#: _______________________________

Patient Initials _____________

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Patient Name:____

Emergency Contact Name:____

Relationship:____________________________Phone#:(_____)______________

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No ____________________

Relation to you:_______________________________________

Living Will for Healthcare: ☐ Yes* ☐ No *Please provide a copy for our records

Primary Insurance Carrier: ____

Name of primary policyholder:____

Policyholder’s Date of Birth: ______________ Policyholder’s SSN: ____________________

Policyholder’s employer: ____

Insurance ID#:____________________Group#:______________________________

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage:____

Secondary Insurance Carrier:_______________________________________

Name of primary policyholder:____

Policyholder’s Date of Birth: ______________ Policyholder’s SSN: ____________________

Policyholder’s employer: ____

Insurance ID#:____________________Group#:______________________________

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage:____

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

Signature:__________________________________Date:________________________

Patient Initials __________

MRN:

cCARE
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FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:______________________________

Reason For This Visit:______________________________

____

MEDICAL HISTORY: (Check the items that apply to you, currently or in the past)

	Date of Diagnosis		Date of Diagnosis
☐ Bleeding Disorder	________	☐ Kidney Stones	________
☐ HIV/AIDS	________	☐ Stroke	________
☐ Diabetes -Type I, Type II	________	☐ Seizures	________
☐ Thyroid Disorder	________	☐ Obesity	________
☐ High Blood Pressure	________	☐ Arthritis	________
☐ High Cholesterol	________	☐ Alcoholism	________
☐ Heart Trouble	________	☐ Reaction to Anesthetic	________
☐ Allergy or Asthma	________	☐ Glaucoma	________
☐ Cancer	________		

OTHER ILLNESS OR MEDICAL PROBLEMS: (Please list current and past medical problems that you have been treated for and the physician who treated you)

Illnesss / Medical Problem	Physician

PAST SURGICAL HISTORY: (Please list any of the surgeries and/or procedures that you have undergone)

Surgery / Procedure	Performing Physician

CURRENT MEDICATIONS: (ATTACH MEDICATION LIST IF NEEDED)

Name	Strength/Frequency	Prescriber

ALL NON-PRESCRIPTION MEDICATION INCLUDING VITAMINS AND HERBS:

Pharmacy______________ Address______________________ Phone#____________

Patient Initials __________

MRN:

cCARE CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:____

ALLERGIES AND SENSITIVITIES:

(List any Allergies to medications or foods that you have and how each affects you.)

☐ No known allergies ☐ No known drug allergies

Allergy	Reaction
______________________	______________________________________
______________________	______________________________________
______________________	______________________________________
______________________	______________________________________
______________________	______________________________________

FAMILY MEDICAL HISTORY:

Indicate any family members with breast, ovarian, pancreatic, prostate, melanoma, colon, kidney or uterine cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	______	______________	______________________
Mother:	______	______________	______________________
Sisters/Brothers:	______	______________	______________________
Children:	______	______________	______________________
Aunts/Uncles:	______	______________	______________________
Maternal Grandparents:	______	______________	______________________
Paternal Grandparents:	______	______________	______________________

SOCIAL HISTORY

Work Hazards:

Any occupational hazards (like noise or chemical exposures) ☐ Yes ☐ No If yes, what:________________

Tobacco Use: (Present and/or past)

☐ Never smoked

☐ Quit smoking When?__________ How many years did you smoke?_____yr(s) How many packs?_____/day

☐ Currently smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes

How many packs?_____/day How many years?_____

☐ Chewing tobacco ☐ Current ☐ Past How long?_____

Alcohol Use: (Present and/or past)

☐ Non drinker

☐ Beer number of bottles _______ per ☐ Day ☐ Week ☐ Month

☐ Wine number of glasses _______ per ☐ Day ☐ Week ☐ Month

☐ Liquor number of glasses _______ per ☐ Day ☐ Week ☐ Month

Females:

Age at first period______ Age at last period______

# of pregnancies______ # of live births______ Age at first pregnancy______

☐ Birth control use,______ # of years

☐ Hormonal replacement______ #of years

Patient Initials ______________

MRN:

cCARE CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:____

NUTRITIONAL HISTORY:

Has there been a change in your appetite in the past 6 months? ☐ Yes ☐ No

Have you gained or lost weight (more than 10 lbs.) in 1 month without wanting to? ☐ Yes ☐ No

If yes how much gain or loss?__________

Are you happy with your weight? ☐ Yes ☐ No

If not, are you on a diet and exercise program? ☐ Yes ☐ No

For women: Are you taking any extra calcium? ☐ Yes ☐ No

REVIEW OF SYSTEMS: (Please check any **CURRENT** symptoms you have.)

Constitutional Symptoms

☐ No Fatigue	☐ Fatigue	
☐ No Fever	☐ Fever	
☐ No Chills	☐ Chills	
☐ No Weight Loss	☐ No Weight Change/Stable	Weight Loss _______lbs.
☐ No Night Sweats	☐ Night Sweats	
☐ No Generalized Weakness	☐ Generalized Weakness	
☐ Appetite Good	☐ Appetite Fair	☐ Appetite Poor
☐ No Sleep Disturbance	☐ Sleep Disturbance	
☐ No Hot Flashes	☐ Hot Flashes	

HEENT (Eyes, Ears, Nose & Throat)

☐ No Blurred Vision	☐ Blurred Vision
☐ No Double Vision	☐ Double Vision
☐ No Sensitivity to Light	☐ Sensitivity to Light
☐ No Dry Eyes	☐ Dry Eyes
☐ No Excessive Tearing	☐ Excessive Tearing
☐ No Hearing Loss	☐ Hearing Loss
☐ No Ringing in Ears	☐ Ringing in Ears
☐ No Mouth Sores	☐ Mouth Sores
☐ No Dry Mouth	☐ Dry Mouth
☐ No Altered Taste	☐ Altered Taste
☐ No Sinus Tenderness	☐ Sinus Tenderness
☐ No Nosebleeds	☐ Nosebleeds
☐ No Hoarseness	☐ Hoarseness

Respiratory

☐ No Difficulty Breathing	☐ Shortness of Breath at Rest	☐ Shortness of Breath with Exertion
☐ No Wheezing	☐ Wheezing	
☐ No Cough	☐ Dry Cough	☐ Productive Cough
☐ No Hemoptysis	☐ Coughing Up Blood	

Cardiovascular

☐ No Chest Pain	☐ Chest Pain
☐ No Palpitations	☐ Palpitations
☐ No Swelling	☐ Swelling

CONTINUE REVIEW OF SYSTEMS ON BACK

Patient Initials __________

cCARE CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:______________________________

REVIEW OF SYSTEMS CONTINUED: (Please check any **CURRENT** symptoms you have.)

Gastrointestinal

- ☐ No Nausea ☐ Nausea
- ☐ No Vomiting ☐ Vomiting
- ☐ No Difficulty Swallowing ☐ Difficulty Swallowing
- ☐ No Heartburn ☐ Heartburn
- ☐ No Abdominal Pain ☐ Abdominal Pain
- ☐ No Diarrhea ☐ Diarrhea
- ☐ No Constipation ☐ Constipation

Genitourinary

- ☐ No Hematuria ☐ Hematuria
- ☐ No Pain with Urination ☐ Pain with Urination
- ☐ No Urgency ☐ Urgency
- ☐ No Incontinence ☐ Incontinence
- ☐ No Urination during night ☐ Urination during night
- ☐ No Hesitancy ☐ Hesitancy

Musculoskeletal

- ☐ No Bone Pain ☐ Bone Pain
- ☐ No Muscle Pain ☐ Muscle Pain
- ☐ No Back Pain ☐ Back Pain
- ☐ No Joint Pain ☐ Joint Pain
- ☐ No Joint Swelling ☐ Joint Swelling
- ☐ No Limited Range of Motion ☐ Limited Range of Motion

Integumentary (Skin)

- ☐ No Rash ☐ Rash
- ☐ No Itching ☐ Itching
- ☐ No Skin Lesions ☐ Skin Lesions

Neurological

- ☐ No Headache ☐ Headache
- ☐ No Focal Weakness ☐ Focal Weakness
- ☐ No Paralysis ☐ Paralysis
- ☐ No Neuropathy ☐ Neuropathy
- ☐ No Seizures ☐ Seizures
- ☐ No Speech Impairment ☐ Speech Impairment
- ☐ No Tremor ☐ Tremor
- ☐ No Altered Consciousness ☐ Altered Consciousness

Hematologic

- ☐ No Excessive or Spontaneous Bleeding or Bruising ☐ Excessive or Spontaneous Bleeding or Bruising

Mental Health

- ☐ No Anxiety ☐ Anxiety
- ☐ No Depression ☐ Depression
- ☐ No Insomnia ☐ Insomnia
- ☐ No Panic Disorder ☐ Panic Disorder

Sexual History

- ☐ Reports Sexual History

Breast

- ☐ No Nipple Discharge ☐ Nipple Discharge
- ☐ No Mass ☐ Mass
- ☐ No Pain ☐ Pain
- ☐ No Nipple Inversion ☐ Nipple Inversion
- ☐ No Skin Changes ☐ Skin Changes
- ☐ No Axillary Mass ☐ Axillary Mass

Patient Initials ____________

MRN:

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

HEALTH INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO cCARE AND ITS ASSOCIATES

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Patient Name: ______________________ SSN: ______________________
Please Print

Telephone Number: ______________________ DOB: ______________________

INFORMATION TO BE RELEASED FROM/TO: ☐ FROM ☐ TO

I hereby authorize the release of information in my medical record from/to (Provider Name):

____

Address ______ City ______ State ______ Zip Code ______

Phone ______ Fax ______

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/or test results. Exclusions to the above: ______________________

____

INFORMATION TO BE RELEASED FROM/TO: ☐ FROM ☐ TO

☐ **4S RANCH**
16918 Dove Canyon Rd
Suite 103
San Diego, CA 92127
Ph: 858.649.5100
Fax: 858.649.5099

☐ **ENCINITAS**
326 Santa Fe Drive
Suite 105
Encinitas, CA 92024
Ph: 760.452.3340
Fax: 760.452.3344

☐ **LA JOLLA**
9850 Genesee Ave
Suite 560
La Jolla, CA 92037
Ph: 858.552.1410
Fax: 858.552.0929

☐ **MURRIETA**
25405 Hancock Ave
Suite 206
Murrieta, CA 92562
Ph: 760.733.9191
Fax: 760.733.9192

☐ **SAN MARCOS**
838 Nordahl Road
Suite 300
San Marcos, CA 92069
Ph: 760.747.8935
Fax: 760.747.7951

☐ **FRESNO**
7130 N. Millbrook Ave
Fresno, CA 93720
Ph: 559.326.1222
Fax: 559.447.4925

TYPE OF RECORD:

- ☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Psychotherapy notes only
- ☐ Radiology reports (Specify): ______________
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report
- ☐ Other Information (Specify): ______________

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)

☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: ______________

CONTINUED ON BACK

MRN:

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RESTRICTIONS/DURATION/RIGHTS

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE: ______________________________ **DATE:** ____________________
(Patient/Legal Representative/Guardian)

If signed by other than patient, indicate relationship: ______________________________

Witness: ______________________________ ______________________________
Print Name Signature

(PHYSICIAN PART ONLY) Records obtained in the course of PSYCHIATRIC TREATMENT

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (Note: No approval is required for release to the patient's attorney.)
If denied, please provide reason: ______________________________

Signature: ______________________________ Date: ____________________
(Physician/Psychologist/Social Worker)

Interpreter Signature if Applicable:

I have accurately and completely read the forgoing document to ______________________________
Patient's or Legal Representative's name

In ____________________, the patients or legal representative's primary language.
Language

He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

Interpreter's name: ______________________________ Signature: ______________________________

SAN DIEGO Medical Records:	Phone: 760.747.8935	Fax: 760.747.7951
FRESNO Medical Records:	Phone: 559.326.1206	Fax: 559.326.1233

MRN:

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS PATIENT FINANCIAL RESPONSIBILITY FORM

PLEASE PRINT CLEARLY

Patient's Name:____ DOB:____________________

Thank you for choosing cCARE as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to cCARE to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to cCARE.

USE OF PHOTOGRAPHY

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-PRESCRIPTION FOR MEDICATION HISTORY

We may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

PATIENT FINANCIAL RESPONSIBILITIES

- I (or patient's guardian, if minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include but are not limited to:
  - Charge for returned checks.
  - Charge for the copying and distribution of patient medical records.
  - Charge for forms completion.
  - Charge for missed appointments.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize cCARE to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to cCARE. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian ____ Date ____________________

CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PLEASE PRINT CLEARLY

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ No, please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ Yes, allow communication with:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care ☐ Billing and Payment Information

May We Contact you at:

Home? ☐ Yes ☐ No Number_______________ Work? ☐ Yes ☐ No Number_______________

Cell? ☐ Yes ☐ No Number_______________

Via Email? ☐ Yes ☐ No Email address:_______________________________

May we send appointment reminder via text? ☐ Yes ☐ No

May we leave a message on your answering machine or cell? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following:_______________________________

May we leave a message with a family member or other person at your home? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following:_______________________________

I________________________, understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practice for cCARE.

Patient Signature ______________ Print Name ______________ Date ______________

Date of Birth:________________________

MRN:

cCARE
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FOR RESEARCH & EXCELLENCE

PATIENT PAYMENT POLICY

Dear Patient,

Thank you for choosing cCARE as your health care provider. We are committed to providing you with quality health care. 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 in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **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, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
   a. Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments. All co-payments must be paid at the time of service.** This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Missed appointment policy.** Our policy is to charge an assessment fee to patients who miss their appointments, or who cancel an appointment with less than 24 hours' notice.
   Fees: $50.00 fee per missed office visits.
   $100.00 fee for procedure visits.
   $150.00 fee for missed PET Scan visits.
   These charges will be your responsibility and billed directly to you. Your insurance will not pay them. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Payment.** For your convenience, cCARE accepts Checks and Credit Cards. We accept Visa, Master card, Discover and American Express.
10. **Financial Counselor**. We have a Financial Counselor available as a resource to our patients.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

______________________________ ______________________________
Signature of Patient or Responsible Party | Date

______________________________ ______________________________
Print Name | Relationship to Patient

MRN:

NO-SHOW / LATE ARRIVAL POLICY & ELECTRONIC COMMUNICATION POLICY

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show and Late Arrival Policies as follows.

NO SHOW POLICY

Effective April 1, 2018, we will implement a "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence - Patient/parent will receive a letter advising of our policy.
- Second occurrence - Patient/parent will receive a second letter and a $50.00 no-show fee assessment for office visits and a $100.00 no-show fee assessment for procedure visits.
- Third and subsequent occurrences - May result with an additional $100.00 no-show fee.

LATE ARRIVAL POLICY

Patients arriving more than 10 minutes late for a scheduled office visit or procedure appointment will be rescheduled for another day.

ELECTRONIC COMMUNICATIONS

For your convenience our office communicates through different electronic means including our secure patient portal, phone, and text messaging for appointment reminders.

Please check below if you do NOT want to be contacted by cCARE in any of the following methods of communication:

☐ Cell Phone ☐ Text Message ☐ Home Phone ☐ Secure Email ☐ Online Patient Portal

Is it okay to leave a detailed message on your voicemail? ☐ Yes ☐ No

Signature of Patient or Representative ______________________ Date ______________________