# Cancer & Blood Disorders Treatment and Infusion Center

Phone: 301-638-1007
Fax: 301-638-1009

## PATIENT REGISTRATION

**PLEASE PRINT CLEARLY**

| PATIENT NAME First | Middle | Last | | DATE OF BIRTH | AGE |
|---|---|---|---|---|---|
| HOME ADDRESS | APT. NO | CITY | STATE | ZIP CODE | |
| OCCUPATION: | SOCIAL SECURITY NO. | MARITAL STATUS ☐S ☐M ☐D ☐W | SEX | PHONE # | |
| EMPLOYER (or previous employer, if retired) | ADDRESS | | | WORK # | |
| SPOUSE (or Parent) NAME | SPOUSE (or Parent) EMPLOYER | | | SPOUSE (or Parent) WORK PHONE | |
| EMAIL ADDRESS: | | | | | |
| NEAREST RELATIVE/FRIEND | RELATIONSHIP | HOME PHONE | | WORK PHONE | |
| RELATIVE/FRIEND ADDRESS | | | | | |
| REFERRING PHYSICIAN | ADDRESS | | | TELEPHONE | |

### POLICY CONCERNING PAYMENT OF MEDICAL BILLS

It is our policy that we will file all claims to those insurance companies in which we are a participating provider. You are responsible for all co-payments and deductibles at the time of service. If we do not participate with your insurance plan, payment is expected at the time of service. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, money order, checks and Visa/MasterCard.

If my account becomes assigned to a collection agency, I agree to pay the 25% collection agency fees associated with my account balance. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

X ______________________________

### BILLING AND INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| PRIMARY INSURANCE | INSURANCE COMPANY NAME | | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | SUBSCRIBER'S NAME | SEX | HOME PHONE | RELATIONSHIP TO PATIENT |
| | SUBSCRIBER'S ADDRESS | | WORK PHONE | SUBSCRIBER'S DATE OF BIRTH |
| SECONDARY INSURANCE | INSURANCE COMPANY NAME | | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | SUBSCRIBER'S NAME | SEX | HOME PHONE | RELATIONSHIP TO PATIENT |
| | SUBSCRIBER'S ADDRESS | | WORK PHONE | SUBSCRIBER'S DATE OF BIRTH |

## PATIENT'S AUTHORIZATION

______________________________, hereby authorize CANCER & BLOOD DISORDERS TREATMENT CENTER, to apply for benefits on my behalf for covered ɜrvices rendered. I request payment from BC/BS National Capitol Area, Blue Shield of Maryland, Medicare, and/or ______________________________.

(Name of Other Insurance Company)

ɜertify that the information I have reported with regards to my insurance coverage is correct and further authorize the release of any necessary information, including edical information for this or any related claim, to the above-named billing agent, (or in the caseof Medicare Part B benefits, to the Social Security Administration ɪd Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This ɪthorization may be revoked by either me or the above-named carrier at any time in writing.

X ______________________________ ______________________________

Signature of Subscriber or Beneficiary — Date

Office Hours by Appointment
www.cancerandblooddisorderscenter.com

# -Medical History

## Cancer & Blood Disorders Treatment and Infusion Center

Name: ______________________________ Date: ____________
Age: __________ Date of Birth: ______________
Sex: ____M ____F
Occupation: ______________________________________________

**Allergies to Medications, X-Ray dyes, or other substances:** ____No ____Yes
If yes, please list the names of medications & type of reaction:
____________________________________________________________
____________________________________________________________

**Past Medical History & Review of Systems**
Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. High Cholesterol
4. Arthritis
5. Heart Problems
6. Lung Problems
7. Stomach Problems
8. Liver Problems
9. Skin Problems
10. Bone Problems
11. Urinary Problems
12. Psyche Problems
13. Blood Clotting Problems
14. Anemia

Any other problems, please briefly explain in space below
____________________________________________________________
____________________________________________________________

**Past Surgical History & Recent Hospitalizations**
Please list all surgical procedures
____________________________________________________________
____________________________________________________________
____________________________________________________________

**Medications**

| Medication Name | Dosage | Prescription, Over the counter, etc. |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

# Cancer & Blood Disorders Treatment and Infusion Center

Phone: 301-638-1007

Fax: 301-638-1009

Name: ____________________ DOB: ______________________

Height: ___________ Weight: ____________

Do you smoke? YES OR NO

If not, have you ever smoked in the past? YES OR NO

## ***ADVANCED DIRECTIVES***

(PLEASE CIRLCE ONE)

1. DO YOU HAVE A LIVING WILL? YES OR NO
2. DO YOU HAVE A POWER OF ATTORNEY? YES OR NO
3. DO YOU HAVE A DNR (DO NOT RESUCITATE) IN PLACE?

YES OR NO

# A Notice of Privacy Practices

**CANCER & BLOOD DISORDERS TREATMENT AND INFUSION CENTER**

*Board Certified In Oncology and Hematology*

Tel: (301) 396-9215 Fax: (301) 638-1009

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related to health care services.

1. Uses and Disclosures of Protected Health Information

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, or support the operation of the physician's practice and any other used required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Ownership:** You have the right to know that the physician(s) who are responsible for your care have a beneficial compensation arrangement with the owners of this facility which charges for both professional and technical charges. You may choose to obtain health care services from another health care entity.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected heath information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Communication with Family:** Health professionals, using professional judgment, may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care or payment to your health care.

**Research:** We may disclose your health information for medical research and tumor registry when an instructional review board has approved the research proposal to ensure the privacy of your information.

**Business Associates:** We provide some services in our organization through the contract Health Business Associates. Examples include physician services in the emergency room, certain laboratory tests and a dictation service. To protect your health information, we require the Business Associate to appropriately safeguard your information.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:**
Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation or, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as describes in this Notice of Privacy Practices. You request must state that specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you be mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**
You may complain to use to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **May 10, 2003.**

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name ______________________________

Signature ______________________________

Date ____________________