Central Coast Oncology and Hematology

Amy McMullen, M.D.
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Patient Information (Please print)

Name(Last, First, MI)			
Address		Employer	
City	Zip	Marital Status	Sex
SSN	Phone (H)	DOB	Age
Phone (W)	Phone (C)	Email	
Contact Preference (Please circle all that apply) Home Work Cell Email		Language Preference (Please circle) English Spanish Other:_______________	
Race (Please Circle) American Indian Asian Black or African American Native Hawaiian or Pacific Islander White Other Declined			
Ethnicity (Please circle) Hispanic or Latin or Spanish Non-Hispanic nor Latin nor Spanish Declined			
Emergency Contact Name (Last, First, MI)			
Relation to patient		Phone	

Insurance Information

Primary Care MD		Referring MD
Person responsible for bill/Name of insured (Last, First, MI)		
Address		Relation to patient
City	Zip	DOB
SSN	Phone	Employer
Primary Insurance Carrier		Secondary Insurance Carrier
Policy #		Policy #
Group #		Group #
Reason Medicare is secondary		

The above information is true to the best of my knowledge. I authorize my insurance company to pay directly to Central Coast Oncology & Hematology. I understand that I am financially responsible for any balance, and it is my responsibility to see that my balance for services provided is paid within 60 days of the date of service.

Signature ____

Date__________________

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Santa Cruz, CA 95065

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Consent to Treat

I consent to any examination or procedure rendered me under the instructions of my physician. I recognize the physicians furnishing services to me are independent agents.

Initial _____

Assignment of Benefits to Physician

I hereby give authorization for payment of insurance benefits to be made directly to **Central Coast Oncology & Hematology** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Our Managed Care patients will be responsible for all non-covered services as outlined by their plan. In the event of a default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize **Central Coast Oncology & Hematology** to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Initial _____

Medicare Authorization to Pay Benefits to Physician

Beneficiary Name ____ HIC# _______________________

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Central Coast Oncology & Hematology** for any services furnished to me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have had the opportunity to read/receive a copy of the Notice of Privacy Practices of **Central Coast Oncology & Hematology**.

____ _______________________

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

____

Address

_______________________ _______________________

Telephone (day) Telephone (evening)