

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBLES

Today's Date: _____

Patient Name: _____ (_____) _____ (_____) _____
Last First M.I. Home Telephone Cellular Telephone

Home Address: _____
Street City State Zip Code

Email address: _____ Pager Number: (_____) _____

DOB: _____ Age _____ M F SS# _____ Married Single Divorced Widowed Other
Sex Check Marital Status

Patient Employer: _____ (_____) _____
Name Telephone

Address Occupation

Responsible Party: _____ (_____) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ (_____) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins.: _____ Telephone: (_____) _____ Insured Employer: _____
Claims Address: _____ Insured Name: _____ Relationship to Patient: _____
Insured SS#: _____ DOB: _____ Group #: _____ Policy #: _____
Secondary Ins.: _____ Telephone: (_____) _____ Insured Employer: _____
Claims Address: _____ Insured Name: _____ Relationship to Patient: _____
Insured SS#: _____ DOB: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Austin Cancer Centers. I also authorize agents of any hospital, treatment center or previous physicians to furnish Austin Cancer Centers copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Austin Cancer Centers.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Austin Cancer Centers. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Austin Cancer Centers.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interest third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health and benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with Austin Cancer Centers. Finally, I consent to the disclosure of my protected health information to any physician or facility who is currently or will be participating in my diagnosis, evaluation, treatment, or follow-up care.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY MY IN WRITING

Patient Signature Date/Time AM or PM (circle one)

Responsible Party Signature Relationship Date/Time AM or PM (circle one)

Physician: _____

ACCT NBR: _____ LOC: _____

FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

Confidential

**AUSTIN CANCER CENTERS
History and Physical**

Patient Name:		Date:	
Primary Care Physician:		Drug Allergies: Yes No If "Yes", please explain:	
Medical Oncologist:			
Surgeon:			
Other Physicians:			

Medical History Please list dates of each instance.		
Major Medical Problems (ie. Diabetes, Heart Problems, etc)	Surgeries (Please list approximate dates)	Hospitalizations (Please list approximate dates)

Current Medications Include vitamins and/or herbal products		
Name of medication	Dose	Frequency

Social History	
Are you currently employed?	Yes No Retired
Occupation (current or former):	
Marital status:	
Number of people in household:	
Do you now or have you ever smoked?	Yes No
If "Yes", at what age did your start / quit:	
What tobacco products did/do you use?	
How much per day?	
Do you drink alcohol?	Yes No
If "yes" how much/week:	
Have you been treated for drug/alcohol abuse?	Yes No
Have you been exposed to hazardous materials?	Yes No

Family History	
Is there a history of cancer in your family? Yes No	
If "yes", list below:	
Relationship	Type of Cancer

Treatment Options Please explain any "yes" answers	
Have you had past experience with cancer?	Yes No
Have you had any prior radiation treatments?	Yes No
Have you ever had chemotherapy? If "yes", list last treatment date:	Yes No
Will chemotherapy be a part of your treatment?	Yes No

Patient Signature _____

Nurse Signature _____

Date _____

POLICY FOR ADVANCE DIRECTIVES

Patient Name(Print _____)

Patient Med. Rec # _____

Advance Directives, which include a **Living Will, Medical Power of Attorney** and **Out-of-Hospital Do Not Resuscitate** orders, allow you to state **YOUR** choice for health care if you become unable to make decisions. It is the policy of **Austin Cancer Centers (ACC)** to comply with the provisions of the state law regarding the honoring of our patients' wishes as stated in the patient's advance directives. Patients who have executed advance directives are required to provide **ACC** with a copy of their directive. A copy of the document will be put into your medical chart to ensure that your wishes are honored. Please understand that you are not required to have an advance directive in order to receive proper medical treatment at this facility.

If a patient chooses not to have an advance directive and is involved in an emergency situation, the medical staff will be responsible for making decisions regarding the patient's care. It is the policy of **Austin Cancer Centers** to resuscitate every patient in the event of cardiac/respiratory arrest and to conduct life sustaining procedures until EMS arrives.

As confirmed by my initials, I have executed one or more of the following and I do understand that I must provide a copy to **ACC**.

- 1. **Durable Power of Attorney for Health Care**
- 2. **Living Will** (directive to physicians)
- 3. **Out-of-Hospital Do Not Resuscitate Directive (OHDNR)**.
I understand I must wear an approved I.D. device or carry the original document in a visible manner in order for the document to be honored).
- 4. At this time, I have not executed any of the above directives and am in receipt of the information provided by **Austin Cancer Centers** regarding **Advance Directives**.

AUSTIN CANCER CENTERS

Experienced specialists. Advanced treatment. The standard for compassionate care.

Date: _____

Patient Signature

Witness

AUSTIN CANCER CENTERS

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Accidental Exposures

In the course of care and treatment, health care workers may be accidentally exposed to a patient's blood or body fluids. Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures.

I understand that, in the event a health care worker is exposed to my blood or body fluids, my blood will be tested for the HIV antibody and other communicable diseases at no cost to me. My initials below signify that I understand the information and agree to your proposal.

On behalf of Austin Cancer Centers, we thank you for your cooperation.

Patient Initials _____

Date _____

Pregnancy

Female patients, please let us know if there is any possibility that you may be pregnant.

Yes

No

Patient Initials _____

Date _____

NORTH AUSTIN | 512.901.1180 | FAX: 512.901.1190
12221 Mo-Pac Expressway North (inside North Austin Medical Center)

CENTRAL AUSTIN | 512.505.5500 | FAX: 512.505.5593
2600 E. Martin Luther King Jr. Blvd.

NORTHWEST AUSTIN | 512.531.5200 | FAX: 512.531.5280
11111 Research Blvd., Ste. LL2 (Inside Seton Northwest Hospital)

George R. Brown, MD
Board-Certified Cancer Specialist

Stephen L. Brown, MD
Board-Certified Cancer Specialist

Shannon D. Cox, MD
Board-Certified Cancer Specialist

Douglas J. Rivera, MD
Board-Certified Cancer Specialist

Kirsten A. Warhoe, MD
Board-Certified Cancer Specialist

Call **512.623.5269** or visit online: www.AustinCancerCenters.com

**NOTICE OF PRIVACY PRACTICES
Acknowledgment of Receipt**

Austin Cancer Centers is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information.

Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Austin Cancer Centers.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Austin Cancer Centers Office Use Only

Date acknowledgement received: _____

- OR -

Reason acknowledgement was not obtained:

AUSTIN CANCER CENTERS

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Staff Signature

Date