

Patient Name: _____

Date of Birth: _____

Request for Confidential Communications

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 Phone Number _____	<input type="checkbox"/> Work Phone Number _____
<input type="checkbox"/> Cell Phone 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 at this number if I can't be reached _____	

Emergency and HIPAA Contact Information

In our effort to adhere to HIPAA guidelines, TCA needs your authorization to release information connected with your care to your family members, friends, or other designated persons. We also need to identify person's 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 TCA can provide to them: ___ Medical ___ Financial ___ Both ___ Neither

Secondary Emergency Contact Name: _____

Relationship to me: _____ Phone Number: _____

Type of Information that TCA can provide to them: ___ Medical ___ Financial ___ Both ___ Neither

Name: _____ Relationship to me: _____ Contact Number: _____

Type of Information that TCA can provide to them: ___ Medical ___ Financial ___ Both

Name: _____ Relationship to me: _____ Contact Number: _____

Type of Information that TCA can provide to them: ___ Medical ___ Financial ___ Both

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

I acknowledge that I have been presented with a copy of the Texas Cancer Associates 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 any information needed to determine benefits.

Printed Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

Date

Patient Name: _____

Date of Birth: _____

Texas Cancer Associates Financial Policy

1. Payment is due at the 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, Texas Cancer Associates 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 payment.
3. Our practice has made prior arrangements with many insurance companies and other health plans to accept an 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 of the above payments.
4. Secondary insurance filing will be determined on a case by case basis.
5. If you do not have insurance, payment arrangements must be made prior to service. If you first saw the Physician in the hospital, payment arrangements 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 TCA.
9. I hereby assign, transfer and set over to Texas Cancer Associates 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).

Printed Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

Date