

# Maryland Oncology Hematology P.A. – Columbia

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Last First M.I. Home Telephone

Home Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
Street Street  
City State Zip City State Zip

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

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 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

Insured Name: \_\_\_\_\_ 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 Maryland Oncology Hematology P.A. – Columbia (MOHPA).
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 MOHPA. 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 MOHPA.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from MOHPA.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.**

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 original.

\_\_\_\_\_  
**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 \_\_\_\_\_

**Patient Survey:**

Name:	DOB:	Age:
Address:	City:	State:
Home:	Referring Physician:	
Oncologic History:		
Past Medical and Surgical History:		
Medications:		
Allergies:		
Family History:		
Social History:		
Married:	Number of Children:	

Do you smoke?	How much?	How many years?
Do you drink?	How much?	How many years?
Do you work?	Where?	At what?

**Review of Systems:**

Headache	Cough	Difficulty urinating
Dizziness	Shortness of Breath	Blood in urine
Visual Disturbances	Chest Pain	Pain
Speech Disturbances	Nausea	Anxiety
Stiff Neck	Diarrhea	Depression
Fever	Constipation	
Chills	Blood in Stool	
Night Sweats		
Weight Loss		

Height                      Weight

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Maryland Oncology Hematology, P.A. 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 Maryland Oncology Hematology, P.A.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Personal Representative (if appropriate): \_\_\_\_\_

Signature of Personal Representative (if appropriate): \_\_\_\_\_

Date: \_\_\_\_\_

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(Practice Name) Use Only

Date acknowledgement received: \_\_\_\_\_

-OR-

Reason acknowledgement was not obtained:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MARYLAND ONCOLOGY HEMATOLOGY, P.A.**  
**10710 CHARTER DR., SUITE G020**  
**COLUMBIA, MD 21044**  
**410-964-2212**  
**410-964-0380 FAX**

**ROUTINE DISCLOSURE OF HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize Maryland Oncology Hematology, P.A. to release routine results of lab tests, scans or other diagnostic tests to me or to my designated personal representative as requested.

I authorize Maryland Oncology Hematology, P.A. to release medical information and/or reports regarding my treatment to any federal, state or accreditation agency or any physician or insurance carrier as needed.

I authorize agents of any hospital, treatment center or previous physicians to furnish Maryland Oncology Hematology, P.A. copies of any records of my medical history, services or treatments.

I understand that this release will expire one year from the date of my signature and can be revoked at any time prior to that date at my written request.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

\_\_\_\_\_  
Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient