RADIATION ONCOLOGY CENTERS OF NEVADA
NEW PATIENT INFORMATION FORM

Patient Name ____

SSN :____-____-____ Date of Birth: ____/____/____ Age: _____ Sex: ____ Marital Status: ______
Patient Address: ____ Apt #: _____________
City: ______________________________________ State: ________ Zip Code: __________
Home Phone: ______________________ Cell: _____________________ Work: _____________
Employer: ____

Parent/Guardian Information

Is Patient a Minor: ________ (If yes, Parent/Guardian Information and Signature Are Required)
Parent/Guardian Name: ____
Parent/Guardian SSN: ____-____-____ Sex: _______ Date of Birth: ____/____/____
Relationship: _______________________________ Phone: ________________________________
Address: ____ Apt#: _____________
Employer: __________________________________ Employer Phone: ________________________

INSURANCE INFORMATION

We will need your current insurance card(s) and driver's license or photo ID

Primary Insurance:
Insurance Name: ____
Insurance ID#: ________________________________ Group#: _____________ Effective Date:________
Insured's Name: _____________________________ Relationship to Patient: ______________________
Insured's SSN: ____-____-____ Insured's Date of Birth: ____/____/____ Sex: _____________
Insured's Employer: ____

Secondary Insurance:
Insurance Name: ____
Insurance ID#: ________________________________ Group#: _____________ Effective Date:________
Insured's Name: _____________________________ Relationship to Patient: ___________________
Insured's SSN: ____-____-____ Insured's Date of Birth: ____/____/____ Sex: _____________
Insured's Employer: ____

Are you currently enrolled in Hospice or Living in a Care Home? _______Yes ________ No
If yes: Name:__________________________________ Phone: _________________________________
Address: ______________________________________ City: ________________ State: ______ Zip: _____

Are you receiving benefits from the Veteran's Administration: _________ Yes __________ No

EMERGENCY CONTACT INFORMATION

In case of Emergency other than spouse notify: _________________ Phone: ________________________
Relationship to you: ____
Nearest relative not living with you: ___________________________ Phone: ________________________
Relationship to you: ____

SIGNATURE

I agree that the above is true to the best of my knowledge. Patient or Parent/Guardian
Signature: ____ Date: _____________________

RADIATION ONCOLOGY CENTERS OF NEVADA FINANCIAL AND HEALTH INFORMATION POLICY

Dear Patient:

Thank you for allowing us to provide your health care. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign our Financial Policy, as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks and for your convenience MasterCard, Visa and Discover. We will bill your insurance and your secondary insurance when applicable.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Fees for these services and unpaid deductibles are collected at the time of service and co-payment will be due on a weekly basis during treatment.
2. If the insurance carrier does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite payment.
3. Patient responsibility is to be paid in full 45 days after the completion of services.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Radiation Oncology Centers of Nevada (ROCNV). I hereby assign and direct to pay any and all benefits for medical services provided by ROCNV directly to ROCNV. I hereby authorize the release of medical information to process my claim.

I have read and agree to the terms spelled out in the financial policy and benefits assignment. I understand that this assignment applies to all services performed at ROCNV and is in effect until specifically revoked in writing. I further agree that I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Patient's Signature: ____________________________________ Date: _________________________

Health Information Policy

I have received a copy of ROCNV Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that ROCNV may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications.

I understand that ROCNV may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing.

____

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Patient/Parent/Guardian Signature: _______________________________________Date: ______________

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.