8980 S US-1, STE 105
PORT ST. LUCIE, FL 34952
PH: (772) 281-3060
F: (772) 281-3055

1231 N LAWNWOOD CIR., STE B
FT. PIERCE, FL 34950
PH: (772) 271-4830
F: (772) 271-4835

1094 MILITARY TRL, 1st FLOOR
JUPITER, FL 33458
PH: (561) 295-3355
F: (561) 295-3356

Patient Information Sheet

Name (Last): ________________ (First): ____________________ Preferred: _________________

Address: ____________________ City: ______________ State__________ Zip: ______________

Date of Birth: ________ Gender: ____________Marital Status: Single/Married/Widowed/Divorced (Please circle)

Home Phone: ________________________ Mobile Phone: ____________________________________

Email address: ___________________________________ Preferred Language: ______________________

Pharmacy Name: _______________________ Pharmacy Phone Number or Address: ___________________

Social Security #: ____________________ Consent to receiving text messages: Yes/No (please circle)

Employment: _______________________ Work Phone: _______________________

Emergency Contact: _________________________________Relationship: ________________________

Phone: _______________________________Email: ____

Why are you here today? ____

Allergies: ____

List current medications and dosages: ____

____

List all operations, hospitalizations, or serious illness: Dates:

____ ____

____ ____

List Names of Your Doctors: ____

List any Diagnostic Testing: ____

Referred By: ____

Where did you first hear about Coastal Edge Radiation Oncology? ____________________________________

Have you visited our website www.coastaledgeoncology.com? ____

_____________ ___________________________
Date Patient's Signature

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FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Coastal Edge Radiation Oncology firmly believes that a good doctor/patient relationship is based upon understanding and open communication.

This practice will file all insurance claims to your primary and secondary carriers. Our practice will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services. Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits. If you request your insurance company to pay you directly, we will require full payment when services are rendered.

By law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier, as we feel it if necessary, to work together to resolve any insurance problem.

Payment is expected at time of service. Please be prepared to pay the unpaid insurance percentage, your co-insurance, or any outstanding deductible when services are rendered.

All past due balances are subject to outside collection agency placement. Coastal Edge Radiation Oncology reserves the right to obtain any information needed from credit reporting agencies to ascertain a patient's current financial/credit status. This practice follows CMS and CCI guidelines for billing. Using these guidelines, Coastal Edge Radiation Oncology considers bundled incidental to any services or supplies that are deemed not medical necessary/medical necessity, will be considered non-covered services and will be the patient's responsibility for these non-covered services. You will be responsible to pay the rate we are contracted with your insurance provider.

Our staff is ready and willing to make every effort to assist you with your questions. PLEASE do not hesitate to ask us. We are here to help you.
(772) 281-3060

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO:____________________________________
   MAILING ADDRESS:____________________ PHONE # :(   )____________
   CITY:____________________ STATE:__________ ZIP:________
   POLICY #:____________________ GROUP #:____________
   INSURED PERSON'S NAME:__________ INSURED PERSON'S S.S. #:__________
2. SECONDARY INSURANCE CO:____________________________________
   MAILING ADDRESS:____________________ PHONE # :(   )____________
   CITY:____________________ STATE:______ ZIP:________
   POLICY #:____________________ GROUP #:____________
   INSURED PERSON'S NAME:________ INSURED PERSON'S SOC. SEC. #:__________

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LIFETIME AUTHORIZATION
MEDICARE AND/OR OTHER INSURANCE – CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or Carriers any information needed for this or related **Medicare** and or **Other Insurance** claim. I request that the payment of authorized benefits for **Medicare** or **Other Insurance** Companies be made to Coastal Edge Radiation Oncology on my behalf.

FOR **MEDICAID PATIENTS:** I certify that I am a recipient of the Medicaid program, Title XIX, and request that payment of authorized benefits be made on my behalf. I authorize Coastal Edge Radiation Oncology to make available to the Florida Department of Children and Family Services any request information concerning medical insurance and financial records related to my treatment. I hereby certify all health insurance shall be assigned to Coastal Edge Radiation Oncology.

I request that this authorization also apply to all **Other Insurance**

I understand the above policy and agree that, after any contractual arrangements between Coastal Edge Radiation Oncology and the insurance carrier are satisfied, I am ultimately responsible for the balance on this account.

________________________ Signature

__________________ Date

________________________ Printed Name

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ________________________, understand that as part of my health care Coastal Edge Radiation Oncology, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Coastal Edge Radiation Oncology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Coastal Edge Radiation Oncology, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Coastal Edge Radiation oncology change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

____
Patient's Signature

____
Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. YOUR RIGHTS WITH RESPECT TO YOUR CONFIDENTIAL INFORMATION
   - a. To inspect, copy (including a paper copy) and receive information
   - b. To request the right to amend your information (although we are not required)
   - c. To receive an accounting of non-routine or non-authorized disclosures of your information for 6 years
   - d. To request a restriction on certain uses and disclosures of your information (although we are not required to do so)
   - e. To file a complaint if you believe your rights have been violated

2. THE FOLLOWING ARE VARIOUS USES AND DISCLOSURES OF YOUR CONFIDENTIAL PATIENT INFORMATION THAT MAY BE USED BY YOUR PHYSICIAN (No specific medical consent is required)
   - a. For your medical treatment
     - i. For example, your health care team may share your medical information including their observations, in order to determine how you are responding to treatment
     - ii. For example, we may use your health care information to contact you regarding an appointment
   - b. To bill for your medical services
     - i. For example, a bill may be sent to your insurance company which contains your diagnosis, procedure performed or supplies used.
   - c. For our operational purposes
     - i. For example, your information may be used in connection with quality improvement activities in order to improve the quality and effectiveness of the services we provide.
     - ii. For example, our business associates may need access to your confidential information so they can perform the job we asked them to do. Business associates include accreditation agencies, state hospital associations, our attorneys and accountants.

3. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MAY MAKE UNLESS YOU OBJECT
   - a. To family and friends involved in your care
   - b. With respect to treatment alternatives or other health related benefits which may be of interest to you

4. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MUST MAKE
   - a. When required by state or federal law
   - b. To state and federal public health authorities for disease prevention
   - c. To protective service agencies authorized to receive reports of abuse, neglect and domestic violence
   - d. To governmental oversight agencies
   - e. When required pursuant to a court order
   - f. For law enforcement purposes
   - g. To a coroner, medical examiner or funeral director for the purpose of carrying out their duties
   - h. To organ procurement organizations
   - i. Pursuant to established research protocols (IRB or Privacy Board approval)
   - j. When required to avert a serious threat to health or safety
   - k. In connection with workers compensation programs

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Any other uses other than what is described above is prohibited unless specific authorization is given by you. You have the right to revoke such authorization at any time in writing, except to the extent we have already relied on it.

5. OUR DUTIES
   a. We are required to maintain the confidentiality of your medical information and to provide you with notice of our legal duties and privacy practices
   b. We are required to abide by the terms of this Notice
   c. We reserve the right to change the terms of this Notice and will post the new notice when it becomes effective

6. RIGHT TO COMPLAIN
   a. You may complain to the office manager or privacy officer if you believe your rights identified in this Notice have been violated. Contact our office for the form for filing a complaint.
   b. If you are unhappy with how your complaint was handled, you may contact the Secretary of Health and Human Services.
   c. The law prohibits any retaliation for filing a complaint

7. FOR FURTHER INFORMATION
You may contact the office at (772)281-3060 for any further information with respect to this policy.

____
Patient Signature (or legal representative)

____
Date

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RELEASE OF MEDICAL RECORDS

PATIENT NAME: ______________________________

DATE OF BIRTH: _____________________________

SOCIAL SECURITY NUMBER: __________________

The above-named patient has been referred to us for radiation therapy. We would appreciate your sending us the medical records indicated below:

- ☐ Operative Reports
- ☐ Clinical Notes
- ☐ Pathology Reports
- ☐ Radiation Therapy Records
- ☐ Imaging Reports
- ☐ Other: ____________________

Please forward these as soon as possible directly to the Radiation Oncologist at the fax number or address listed above.

I hereby authorize the release of my medical records as requested above.

____
Patient (or Authorized Representative) Signature

____
Date