

PLEASE PRINT CLEARLY

Minneapolis Radiation Oncology, P.A. Clinic: _____ Physician: _____

TODAY'S DATE _____ REFERRING PHYSICIAN: _____

PATIENT NAME _____ DIAGNOSIS _____

ADDRESS _____ CONSULT DATE _____

CITY/STATE _____ ZIP CODE _____

PHONE () _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ M/F _____ MARITAL STATUS _____ (M/S/D/W)

EMPLOYER _____ WORK PHONE _____

OCCUPATION _____ FULLTIME/PART TIME _____

SPOUSE: NAME _____ WORK PHONE _____

EMPLOYER _____

EMERGENCY CONTACT :
NAME: _____ HOME PHONE _____

WORK PHONE _____

INSURANCE INFORMATION (Please give complete information)

***Medicare Patients: If your claims go to Medicare first, list Medicare as your primary carrier.

INSURANCE PRIMARY: _____
ADDRESS: _____
CITY/ STATE: _____

POLICY HOLDER INFORMATION (REGUIRED BY INSURANCE COMPANIES)

POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH _____ EMPLOYED Y N
EMPLOYER'S NAME (PAST OR PRESENT) _____
POLICY # _____ GROUP # _____

INSURANCE SECONDARY: _____
ADDRESS: _____
CITY/ STATE: _____

POLICY HOLDER INFORMATION (REGUIRED BY INSURANCE COMPANIES)

POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH _____ EMPLOYED Y N
EMPLOYER'S NAME (PAST OR PRESENT) _____
POLICY # _____ GROUP # _____

**PLEASE HAVE YOUR INSURANCE CARDS READY TO BE COPIED.
THANK YOU.**

MINNEAPOLIS RADIATION ONCOLOGY PA

CONSENT FOR SERVICES

I voluntarily consent to evaluation and diagnostic testing which my physician determines to be necessary. I consent to the taking of photographs for medical record documentation. I am aware that Minneapolis Radiation Oncology, P.A. has health care personnel in training who may be present during care as part of their education.

I consent to the release of protected health information to any health care provider involved with my care. I consent to the release of protected health information for treatment, operations (and research) and payment.

I authorize Minneapolis Radiation Oncology, PA/Mid Minnesota Radiation Oncology, PA:

- To release to my insurance company and/or Centers for Medicare and Medicaid Services (CMS) protected health care information as needed for claims processing, fraud investigation or quality of care review and studies.
- To bill for and receive direct payment for any service furnished to me by that physician/clinic.
- To act as my agent in helping me obtain payment from my insurance company.
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I understand that I am responsible to comply with the rules and regulations of my insurance company regarding precertification and prior authorization requirements. I understand that I am responsible for my bill.

I permit a copy of this authorization to be used in place of the original.

I authorize release of protected health care information to the following family members/significant others:

- List by name('s): _____

- Emergency Contact (other than spouse) Name _____

Home Phone _____ Work Phone _____

If the Radiation Therapy Clinic needs to contact me, they may leave a message at the following telephone numbers:

I acknowledge that I have received the Summary Notice of Privacy Practices and Billing Procedures Sheet.

I understand that I may revoke this consent for release of protected health information at any time by notifying Minneapolis Radiation Oncology, P.A. in writing, but that such revocation will not apply to information already released.

Date (Authorization valid for one year)

Patient Signature

5/2003

Print Patient Name

If patient unable to sign: Legal Representative Signature