GASTON HEMATOLOGY & ONCOLOGY ASSOCIATES
PATIENT INFORMATION (Please Print) Date ______________________________

PATIENT INFO

Name Mr. Mrs. Miss ____
(Circle One) Last First Middle

Address ____

City ______________________________ State __________ Zip ______________

Home Telephone ______________ Date of Birth __________ ◽Male ◽Female Age ______ Marital Status ______

Referred By ______________________________ Social Security Number ______________

Patient's Employer ____

Employer Address ____

City ______________________________ State __________ Zip ______________

Employer Telephone ______________________________

RESPONSIBLE PARTY ◽**Self** ◽**Spouse** ◽**Other** ***(Check One)***

Name ____
Last First Middle

Address ____

City ______________________________ State __________ Zip ______________

Home Telephone ______________ Date of Birth __________ Social Security Number ______________

Employed By ____

Business Address ______________________________ Telephone ______________

IN CASE OF EMERGENCY, CONTACT ____

Relationship ______________________ Work Phone__________ Home Phone ______________

PLEASE GIVE US YOUR INSURANCE CARD SO THAT WE CAN MAKE A COPY FOR OUR FILE

PRIMARY INSURANCE

Name of Insurance Company ______________________ Address ______________________

Policy or Certificate Number ______________________ Group Number __________ Copay $________

Insured's Name ______________________ Effective Date of Coverage ______________

SECONDARY INSURANCE

Name of Insurance Company ______________________ Address ______________________

Policy or Certificate Number ______________________ Group Number __________ Copay $________

Insured's Name ______________________ Effective Date of Coverage ______________

PLEASE COMPLETE BACK OF FORM

ASSIGNMENT AND RELEASE (All Patients)

I, the undersigned, have insurance with ____
and assign directly to Gaston Hematology & Oncology Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and required to pay any co-pays at time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

______________________________ ______________________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION (Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Gaston Hematology & Oncology Associates for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Gaston Hematology & Oncology and Doctor ______________________________ and his/her staff to disclose my personal medical information to the following individual(s):

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Conditions for Disclosure (Check the item(s) that apply):

- ☐ The practice may disclose my personal health information to the individual(s) above **only** in my presence.
- ☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.
- ☐ Other Conditions of Disclosure: ____

____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: ____

Date of Signature: ____