

Acct. # _____

Date _____

Hematology Oncology of Salem, LLP

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

| | | | | | | |
|---|--|---|---|---------------------------------|--|-----|
| Patient's Name (Last, First, MI) | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Birth Date | Age | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| Mailing Address | | City | | State | | Zip |
| Street Address | | City | | State | | Zip |
| Home Phone: | Cell Phone: | Patient's Social Security # | | | | |
| Person financially responsible for this account | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent | Responsible Party's Birthdate | Responsible Party's Soc. Sec. # | | |
| Name of Employer | Address | | Business Phone | | Occupation | |
| Name of Spouse | | | | Business Phone | | |
| Referring Physician | Are you currently enrolled in hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Are you currently residing in a skilled nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? | | | |
| Person to contact in case of emergency | | | Relationship to patient | | Phone | |
| Primary Insurance Company | | Address | | | Is insurance through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Subscriber Name | | Subscriber Birth Date | Policy # | | Group # | |
| Secondary Insurance Company | | Address | | | | |
| Subscriber Name | | Subscriber Birth Date | Policy # | | Group # | |

PLEASE READ AND SIGN BELOW.

I HEREBY AUTHORIZE DOCTORS OF HEMATOLOGY ONCOLOGY OF SALEM, LLP TO FURNISH THE PATIENT'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST. THIS AUTHORIZATION SHALL CONTINUE AND BE IN FORCE AND EFFECT UNTIL REVOKED IN WRITING BY ME. I HEREBY ASSIGN TO THE DOCTORS OF HEMATOLOGY ONCOLOGY OF SALEM, LLP ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL EXPENSE RELATIVE TO THE SERVICES PERFORMED FROM TIME TO TIME, BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID PHYSICIANS. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTORS FOR CHARGES NOT COVERED BY INSURANCE. ANY FUNDS I RECEIVE FROM AN INSURANCE COMPANY, MEDICARE OR MEDICAID FOR SERVICES RENDERED TO ME BY HEMATOLOGY ONCOLOGY OF SALEM, LLP SHALL BE IMMEDIATELY PAID OVER TO HEMATOLOGY ONCOLOGY OF SALEM, LLP. REGARDLESS OF INSURANCE PAYMENTS, THE PATIENT OR GUARDIAN IS PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES FOR SERVICES PROVIDED BY HEMATOLOGY ONCOLOGY OF SALEM, LLP. ANY SUMS UNREIMBURSED BY INSURANCE, MEDICARE OR MEDICAID ARE DUE AND PAYABLE WITHIN 30 DAYS OF INVOICING. ANY SUMS NOT TIMELY PAID SHALL BEAR INTEREST AT THE RATE OF 10% PER ANNUM UNTIL PAID. IF HEMATOLOGY ONCOLOGY OF SALEM, LLP HIRE AN ATTORNEY TO COLLECT ANY PAST DUE SUMS, THE PATIENT AND/OR GUARDIAN/PARENT SHALL PAY HEMATOLOGY ONCOLOGY OF SALEM, LLP'S COSTS, DISBURSEMENTS AND REASONABLE ATTORNEY'S FEES INCURRED IN ITS COLLECTION EFFORT, INCLUDING IN TRIAL OR ON APPEAL.

Date _____

PRINT PATIENT NAME_____
PRINT PARENT or GUARDIAN'S NAME_____
PATIENT SIGNATURE_____
PARENT or GUARDIAN'S SIGNATURE