**6410 Rockledge Dr, Suite 660 Bethesda, MD 20817**
**19735 Germantown Rd, Suite 255**
**Germantown, MD 20874**
**Phone (301) 571-0019**
**Fax (301) 571-0988**

| Date | Patient's Last Name | First Name (Legal) & MI | (*Circle One*) Male Female | Marital Status: |
|---|---|---|---|---|
| Address: Street | | City | State | Zip |

| Home Phone | Cell Phone | Work Phone | E-mail | Date of Birth | Social Security No. |
|---|---|---|---|---|---|

| Pharmacy Name: Local:<br>Mail Order: | Pharmacy Phone # Local:<br>Mail order: | Pharmacy Fax # Local:<br>Mail order: |
|---|---|---|

| Referred By (Name, Address, Phone) | Primary Care Physician |
|---|---|
| Occupation | Employer's Name, Address, Phone No. |

| Emergency Contact Name | Relationship | Home Phone | Cell Phone | Work Phone |
|---|---|---|---|---|
| Name of Spouse, Nearest Relative or Friend | Relationship | Home Phone | Cell Phone | Work Phone |

| Primary Insurance | Subscriber's Name | Secondary Insurance | Subscriber's Name |
|---|---|---|---|

| Name of Policy Holder (Address, if different from Patient) | Patient's relationship to Policyholder:<br>Self Spouse Child Other |
|---|---|

| Financially Responsible Person (Name & Address) | Home Phone | Work Phone |
|---|---|---|

## Patient Authorizations

***(Please read, sign and/or initial all sections below)***

1) **Authorization of Payment:** I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to the Center for Cancer and Blood Disorders for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or other Insurance Carriers for which I have coverage, and any information needed to determine these benefits or the benefits payable for related services. I understand that **I am fully responsible for obtaining any necessary referrals** required by my Insurance Carrier and that these must be presented at the time of services. I can exercise my right to be seen without a referral, but must pay for all services in full at the time of service. All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

______________________________________________

**Patient's Signature** **Date**

2) **Authorization for Release of Information:** I do hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person(s) and/or organization(s) authorized to receive the information is not a health plan or a healthcare provider, that the person(s) and/or organizations(s) may also disclose my health information. If this happens, I understand that my information may no longer be protected by the Federal Privacy Regulations. I acknowledge that I have the right to change or revoke this consent, in writing, except where the disclosures were already made in trust on your prior consent. ***NOTE: Health care information will not be released under any circumstances to any relative(s) (spouse, mother, father, sister, brother, etc.), friend(s) or other person(s) unless specifically authorized by the patient below:*** ________ (Patient's initials)

Name of Authorized Person or Organization | Relationship | Phone #

Name of Authorized Person or Organization | Relationship | Phone #

Name of Authorized Person or Organization | Relationship | Phones #

3) **Authorization for Use of Answering Machine and/or Voicemail:** The Center for Cancer and Blood Disorders physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPPA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone, as well as fax, would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures and surgical posting/scheduling information.

_______ (Initial) **Yes**, I agree to allow the Center for Cancer and Blood Disorders physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following communications devices: (***circle appropriate devices***) **home work cell**

_______ (Initial) **No**, I do not agree to allow the Center for Cancer and Blood Disorders physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone.