MISSOURI CANCER ASSOCIATES

UROLOGY ASSOCIATES of Central Missouri

Legal Name_____ **Name you go by**_____

Social Security# _____ **Date of Birth** _____/_____/_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone _____**Cell Ph**_____ **Wk Ph**_____

Marital Status (circle one): Single Married Divorced Widow Sex: Male Female

Race:_____ **Ethnicity:**_____ **Preferred Language:**_____

Email _____**@**_____

Preferred Contact Method (circle one): home phone cell phone work phone email

Referral Source (circle one)? Yellow Pages, Friend/Relative, Hospital _____**, Insurance, Internet**

Referring Physician _____**Phone** _____

Primary Care Physician (if different from Referring Physician listed above):

Name_____ **Phone**_____

Patient's Employer _____**Occupation**_____

Emergency Contact_____**Phone**_____

Relationship to Emergency Contact_____

Insurance Policy Holder Information (if insurance is through spouse or parent)

Primary Insurance Information:

Name_____ **Relationship**_____ **Date of Birth**_____ **Phone**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Social Security Number_____ **Employer**_____ **Work Phone**_____

Secondary Insurance Information:

Name_____ **Relationship**_____ **Date of Birth**_____ **Phone**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Social Security Number_____ **Employer**_____ **Work Phone**_____

Preferred Pharmacy Information

Preferred Pharmacy _____**Phone** _____

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ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Missouri Cancer Associates for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, responsible person(s) listed, Name of authorized person (specify relationship) or other healthcare providers assisting in my medical care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have been offered a copy of Missouri Cancer Associates' Notice of Privacy Practices.

CONSENT TO TREATMENT:
I authorize Missouri Cancer Associates and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of hepatitis A, B, C and HIV.

I understand that in order for Missouri Cancer Associates to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies. These transmissions are done in a safe manner that protects the privacy of personal information. I agree that Missouri Cancer Associates may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above mentioned federal initiative.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered. I also understand and acknowledge that I am personally responsible to pay Missouri Cancer Associates in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have read and agreed to the provisions on listed on this form and accept the terms. A duplicate of this statement is considered the same as original.

Print Name: _____

_____ _____

Signature of Patient (For patients 17 yrs of age or younger, parent or guardian MUST sign.) **Date**

_____

If legal representative, relationship to patient

The patient above also authorized the disclosure of health and financial information to:

(This is not permission to release your official medical record)

Names of Individual _____ **Phone #**_____

Names of Individual _____ **Phone #**_____