Norman J. Brodsky, M.D.
Michael D. Gauwitz, M.D.
Taghrid A. Altoos, M.D.
Hiral K. Shah, M.D.

Board Certified
Diplomate, ABR
Radiation Oncology

DATE: _____

LAST NAME:_____, FIRST NAME:_____, MI:____ SEX:_____

ADDRESS: _____, CITY: _____ STATE: _____ZIP:_____

PERMANENT ADDRESS: _____

EMAIL ADRESS: _____CONTACT PREFERENCE: PHONE/MAIL/EMAIL

HOME PHONE#: _____ WORK#:_____ CELL#: _____

DATE OF BIRTH: _____SS#: _____ AGE: _____ MARITAL STATUS: _____

EMPLOYER'S NAME: _____ ADDRESS: _____

FULL NAME OF SPOUSE: _____ SPOUSE PHONE NUMBER: _____

IN CASE OF EMERGENCY: (PLEASE NOTIFY- NAME, ADDRESS & PHONE)

_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: (NAME, ADDRESS & PHONE)

_____

WHO REFERRED YOU TO COUNTRYSIDE CANCER CENTER? _____

WHICH DOCTOR DO YOU WISH TO SEE? _____

ARE YOU CURRENTLY ENROLLED IN HOSPICE? _____ IF YES, WHAT IS THE DATE OF ENROLLMENT? _____

LIVING WILL/ADVANCE DIRECTIVE: YES/NO

NEED INFORMATION ON TOPIC: YES/NO

_____ _____

PRIMARY INSURANCE (OR MEDICARE) I.D. NUMBER

_____ _____

NAME OF INSURED (IF NOT YOURSELF) GROUP NUMBER

_____ _____

SECONDARY INSURANCE I.D. NUMBER

_____ _____

NAME OF INSURED (IF NOT YOURSELF) GROUP NUMBER

RACE: (PLEASE CIRCLE) PACIFIC ISLANDER AMERICAN INDIAN ESKINO/ALEUT HISPANIC
AFRICAN/AMERICAN OTHER _____

ETHNICITY: _____ LANGUAGES SPOKEN: _____

_____ _____ _____

PATIENT'S SIGNATURE DRIVER'S LICENSE NUMBER STATE

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MEDICARE/MEDICAID/PATIENT CERTIFICATION/RELEASE INFORMATION & PAYMENT REQUEST

I certify that the information given by me in applying for payment under title XVIII and/or XIX of the Social Security Act of 1972 is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I request that payment to authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles, co-insurance, and/or co-payments and that payment is due at the time services are rendered.

SECONDARY INSURANCE

I request that payment of authorized Medigap benefits be made on my behalf to: Pinellas Radiation Oncology Associates for any service rendered to me by Pinellas Radiation Oncology Associates. I authorized any holder of medical information about me to release my records to Pinellas Radiation Oncology Associates if needed to determine these benefits or the benefits payable for related services. I understand that if I receive such benefits in a payment I will turn payment over to Pinellas Radiation Oncology Associates.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize, request and direct any and all assigned insurance companies to pay directly to Pinellas Radiation Oncology Associates and/or any treating physician the amount due in my pending claims for the benefits under the respective policies. I agree that, should the amount be insufficient to cover the entire expenses, I will be responsible for payment of the difference, and that if the nature of the medical condition be such that it is not covered by said policy depending upon insurance carrier, I will be responsible for payment of the entire bill.

GUARANTEE OF PAYMENT

For services rendered, the undersigned guarantees and promises to pay Pinellas Radiation Oncology Associates and/or any treating physician all charges and expenses incurred in the treatment, including those expenses not covered by any insurance policy presently in force, depending upon the contract between insurance carrier and Pinellas Radiation Oncology Associates.

_____ _____

Patient's Signature **Date**

_____

Witness

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, THE UNDERSIGNED, AUTHORIZE _____

_____

TO RELEASE ALL MEDICAL INFORMATION WHICH IS IN THEIR POSSESSION TO:

PHYSICIAN: _____
COUNTRYSIDE CANCER CENTER
3155 NORTH MCMULLEN BOOTH ROAD
CLEARWATER, FL 33761
(727) 669-9018 PHONE
(727) 669-4308 FAX

_____ **_____**
PATIENT'S NAME **PATIENT'S SIGNATURE**

_____ **_____**
DATE OF BIRTH **SOCIAL SECURITY NUMBER**

I FURTHER AUTHORIZE THE ABOVE NAMED FACILITY TO RELEASE SAID MEDICAL RECORDS TO ANY AUTHORIZED REPRESENTATIVE OF MY HEALTH INSURANCE COMPANY UPON THEIR WRITTEN REQUEST FOR THE PURPOSE OF CASE MANAGEMENT, QUALITY ASSURANCE, UTILIZATION REVIEW OR COMPLIANCE WITH A JUDICIAL OR AGENCY ORDER. I FULLY UNDERSTAND THAT MY MEDICAL RECORDS ARE PRIVILEGED AND CONFIDENTIAL INFORMATION, AND MAY NOT BE DISCLOSED WITHOUT MY PRIOR WRITTEN CONSENT, EXCEPT AS REQUIRED BY LAW.

_____ **_____**
PATIENT/AUTHORIZED SIGNATURE **DATE**

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pinellas Radiation Oncology Associates

With my consent, Pinellas Radiation Oncology Associates (PROA) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to PROA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PROA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PROA's Privacy Officer at 3155 N. McMullen Booth Road, Clearwater, Florida 33761.

With my consent, PROA may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, PROA may mail to my home or other designated locations any items that assist the practice in catting out TPO, such as appointment reminder cards and patient statements.

With my consent, PROA may email to my designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PROA's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, PROA may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Date

_____
Print Name of Patient or Legal Guardian