GREATER WASHINGTON ONCOLOGY ASSOCIATES

RAM S. TREHAN, M.D. *DAYA S. SHARMA, M.D.* *GURDEEP S. CHHABRA, M.D.*
PATRICK A. CROSS, M.D. *WILLIAM K. KELLY, M.D.* *SHAAD ABDULLAH, M.D.*

PATIENT REGISTRATION

Date: _____ (PLEASE PRINT) **Home Phone:** _____

Patient: _____ **Cell Phone**:_____
(Last Name) (First Name) (M.I)

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Sex: _____**M** _____**F** **Age:** _____ **Birthdate**: _____

Marital Status: ___Single ___Married (Spouses Full Name _____
___Widowed ___Separated___Divorced

Patient Employed By: _____

Business Address: _____

Occupation:_____Business Phone: _____

Spouse Employed By: _____

Business Address: _____

Occupation: _____Business Phone:_____

Patient Social Security #: _____ **Spouses Social Security #:** _____

Primary Insurance Carrier: _____ **Policyholder Name:**_____

ID #: _____**Group #:** _____

Secondary Insurance Carrier: _____**Policyholder Name:**_____

ID #: _____ **Group #:** _____

In Case of Emergency: _____**Phone #:**_____

Pharmacy Name: _____ **Phone #:** _____

Primary Care Physician Name: _____ **Phone #**:_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, _____,
(NAME)
herby (authorize _____ to pay and hereby
(INSURANCE COMPANY)
assign directly to **Greater Washington Oncology Associates {R. Trehan, MD, D. Sharma, MD, G. Chhabra, M.D., W. Kelly, M.D., P. Cross, M.D.and S. Abdullah, M.D.}** all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Greater Washington Oncology Associates** will be credited to my account, in accordance with the above said assignment.

_____

Authorized Signature of Subscriber/Patient Date

FOR MEDICARE PATIENTS ONLY:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Greater Washington Oncology Associates** for any services furnished to me by physician or supplier. 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.

_____

Authorized Signature of Subscriber/Patient Date

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

Name:_____ **Phone: 301-593-9035**

The effective date of this Notice of Information Practice is: January 01, 2013

PATIENT CONSENT
CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

X_____
Patient Initial

RELEASE OF INFORMATION

By signing this form, you are granting consent to Greater Washington Oncology Associates to use and disclose your protected health information for the purposes of treatment, payment and health care operation. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notice by telephoning our office at 301-593-9035. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent that we already have used or disclosed your protected health information in reliance on your consent.

X_____	**X**_____	**X**_____
Print Patient Name	**Patient Signature**	**Date**

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claims.

X_____	**X**_____	**X**_____
Print Patient Name	**Patient Signature**	**Date**
X_____	**X**_____	**X**_____
Witness Printed Name	**Witness Signature**	**Date**