Methodist
RICHARDSON RADIATION ONCOLOGY ASSOCIATES

2805 E. President George Bush Highway
Richardson, TX 75082

Phone: (469) 204-6100
Fax: (469) 204-6152

PATIENT

NAME: LAST	FIRST	M.I.	DATE OF BIRTH	AGE

ADDRESS: STREET	APT. #	CITY	ST	ZIP

PHONE: HOME	CELL	WORK

PREFERRED: ☐ HOME ☐ CELL ☐ WORK

SOCIAL SECURITY NUMBER — —	EMERGENCY CONTACT NAME / RELATION	CONTACT PHONE #

SEX	MARITAL STATUS	EMAIL ADDRESS
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT

PARENT OR GUARANTOR

NAME: LAST	FIRST	M.I.	PHONE

STREET ADDRESS	CITY	ST	ZIP

SOCIAL SECURITY NUMBER — —	RELATION TO PATIENT	MARITAL STATUS	SEX
		☐ S ☐ M ☐ D ☐ W	☐ M ☐ F

PRIMARY INSURANCE

☐ **CHECK IF SAME AS GUARANTOR** ☐ **SELF PAY**

PRIMARY INSURED PERSON	INSURED STREET ADDRESS	CITY	ST	ZIP

RELATION TO PATIENT	SOCIAL SECURITY NUMBER — —	INSURED DATE OF BIRTH

INSURANCE COMPANY NAME	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	CLAIM ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

SECONDARY INSURANCE

PRIMARY INSURED PERSON	INSURED STREET ADDRESS	CITY	ST	ZIP

RELATION TO PATIENT	SOCIAL SECURITY NUMBER — —	INSURED DATE OF BIRTH

INSURANCE COMPANY NAME	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	CLAIM ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

How did you hear about us? _____

Methodist Richardson Radiation Oncology Associates

OFFICE POLICY AND PROCEDURES

Office Hours – Monday – Friday 8:00 am – 5:00 pm
Closed for lunch 12:00 pm – 1:00 pm

Registration – All patients must complete a patient information packet before seeing their provider and provide a picture identification card.

Insurance – Insurance cards must be presented prior to each office visit. *Please notify our office if there is a change in your insurance plan or coverage.* We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies. Any dispute for unpaid charges from the insurance company will be billed to the member. ALL PATIENTS MUST HAVE AN INSURANCE CARD IN ORDER TO UTILIZE BENEFITS.

Referrals – Allow 5-7 working days to process routine referrals.

Medication Refills – All prescription refill requests should be called into your pharmacy at least **five (5)** working days before the last pill is taken to allow adequate time for approval. Refills will only be handled during normal business hours Monday through Friday. Narcotic prescriptions (pain medication) will not be refilled after office hours or on weekends.

Appointment/No Show – We request a 24-hour notice for appointment cancellations. Patients with three (3) missed appointments and/or no shows can result in dismissal from this practice. If you no show to your appointment you will be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled office visit.

Behavior – Physical and/or verbal abuse towards the office staff will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.

After Hours – Our phone message will provide patients with a number to call our answering service for emergencies. The answering service will notify the physician on call. Calls for refills will not be returned.

Charges – Full payment is due at the time services are rendered unless other payment arrangements have been made.

FMLA and Insurance Forms – Any paperwork that must be completed by Methodist Richardson Radiation Oncology Associates will require an additional fee of $50. Fee must be paid in advance before forms can be filled out. Please allow 1 week for these forms to be processed.

NSF/Closed Accounts – There will be a $35.00 charge added for returned checks.

Thank you for understanding and agreeing to our policy. We are glad that you have chosen Methodist Richardson Radiation Oncology Associates as your health care provider.

Signature: _____ **Date:** _____

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1. **Authorization to Release Information:**
I authorize MEDHEALTH to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payor for the purpose of obtaining payment on account of (1) **MEDHEALTH,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. **Assignment of Benefits:**
Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for the costs of collection.

I understand that I am responsible for providing **MEDHEALTH** all insurance information at the time of registration to allow for verification of benefits and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to MEDHEALTH. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. **Medicare/Medicaid Assignment of Benefits:** *(If you do not have either of these insurance plans please proceed to signature line.)*

   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

   Initial _____

_____
Patient Printed Name

_____ _____
Patient Signature (or Guarantor if patient is a minor) Date

_____ ☐ Patient under 18 years of age
Witness

_____ _____
Translator Printed Name Translator Signature

Methodist Richardson Radiation Oncology Associates

PATIENT CONSENT FOR DISCLOSURE OF HEALTHCARE INFORMATION FORM

Methodist Richardson Radiation Oncology Associates Notice of Privacy Practices (the "NOTICE") provides information about how Methodist Richardson Radiation Oncology Associates may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. A copy of the current Notice is posted in the waiting room. The Notice contains on the first page, in the top right-hand corner, the effective date. As provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Patient Name	Patient Signature
Print Parent or Legal Guardian Name	Parent or Legal Guardian Signature
Relationship to Patient if Legal Guardian	
Date	Witness Signature

Methodist
RICHARDSON HEMATOLOGY
ONCOLOGY ASSOCIATES
2805 E. President George Bush Turnpike
Richardson, TX 75082

In order to better protect your privacy under HIPAA, we have created this consent form for releasing information to family members and/or other persons of the patient's choosing. This will also be used for consent to leave telephone messages at the selected phone numbers. Many times we have patients whose family members call requesting medical information and legally we are not allowed to release that information without the patient's written consent. Please take a moment to fill out this form, and we will keep it on file in your chart. It will be in effect until such notice is given in writing stating otherwise.

Please Print:

I, _____, date of birth _____ /_____ /_____, hereby give my consent for release of information contained within my medical records. This may include appointment, medical diagnosis and/or treatment to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Okay to leave messages at the following number(s):

☐ Home (_____) _____–_____ ☐ Work (_____) _____–_____

☐ Cell (_____) _____–_____ ☐ Other (_____) _____–_____

Results and/or other correspondence from my physician's office can be mailed to:

☐ Home: ☐ Yes ☐ No

☐ Email: ☐ Yes ☐ No

If yes, provide email address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____