Blood & Cancer Center of East Texas
825 Medical Drive
Tyler, Texas 75701

BASIC INFORMATION FORM

Today's Date: _____ Social Security #: _____

Patient's Full **Legal** Name: _____

Date of Birth: _____ Age: _____ Sex: ❍ M ❍ F Citizenship: _____

Address: _____

Street City, State, Zip

Alternate Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Employer Name: _____

Employer Address: _____

Street City, State, Zip

Occupation: _____ Length of Employment: _____

Marital Status: _____ Spouse's Name: _____

Spouse SSN: _____ Spouse Date of Birth: _____

Spouse Employer: _____

Spouse Employer Address: _____

Street City, State, Zip

Spouse Work Phone: _____ Work Fax: _____

NAME OF EMERGENCY CONTACT: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Address: _____

Street City, State, Zip

Relationship to Patient: _____

Do you have a **LIVING WILL** or **DO NOT RESUCITATE AGREEMENT**? ❍ **YES** ❍ **NO**

*If yes, please bring a copy to your appointment.

*If no, the doctors will be very willing to discuss this with you during your appointment.

Closest Relative or Friend (not living with you):

Name: _____ Relationship: _____

Address: _____

Street City, state, zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

PRIMARY INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICAID)

Name of Insured: _____ Relationship to Patient: _____

Name of Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Phone number for benefits verification: _____

Are you required by your insurance to use ETMC Tyler or Mother Francis Hospital for admissions and/or lab work? ○ YES ○ NO

If YES, please indicate which one: _____

Are you required by your insurance to obtain a referral from your primary care physician to have services performed by our physicians? ○ YES ○ NO

If YES, did you obtain the referral from your primary care physician? ○ YES ○ NO

ADDITIONAL INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICADE)

Name of Insured: _____ Relationship to Patient: _____

Name of Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Phone number for benefits verification: _____

ADDITIONAL INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICAID)

Name of Insured: _____ Relationship to Patient: _____

Name of Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Phone number for benefits verification: _____

One of our physicians has less than 5% interest in the Tyler P.E.T. Imaging Institute, L.P. and our physicians may, on occasion, based on medical necessity, refer patients to the facility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND 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 or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(name of insured) (name of insurance company)

to pay and hereby assign directly to Blood and Cancer Center of East Texas, PA all benefits, if any, otherwise payable to me for his/her services as described on the claim forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Blood and Cancer Center of East Texas, PA will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our financial Counselor. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. Our financial policy is:

Unless you or your insurance company has made other arrangements, in advance, payment is due at the time of service. For your convience we will accept cash, personal checks, Visa, or MasterCard.

• **MEDICARE.** We Accept assignment on Medicare claims. If you have Medicare, you will be required to pay your 20% co-pay and your deductible or show proof that you have met your deductible, at the time of your visit.

• If our physician is **not** a provider with your insurance company, as a courtesy, we will file your claims for you, if you assign benefits to our physician. If your insurance company does not pay within a reasonable time, you will be responsible for payment.

• If our physician **is** a provider with your insurance company, we will file your claim and you will be responsible for deductibles and co-payments at the time of service.

• **PATIENT RESPONSIBILITY.** Unless our contract with your insurance company states otherwise, you will be billed for services designated by your insurance company as patient responsibility. Services designated as non-covered by your plan will become patient responsibility.

• **EXCLUDED SERVICES.** For services considered "excluded" by your insurance plan that we deemed medically necessary by the staff and physicians of Blood & Cancer Center of East Texas your signature below requests that the Blood & Cancer Center of East Texas render the services unless otherwise stated in writing.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date