Blood and Cancer Institute of Little Rock
500 S. University Ave., Suite 808, Little Rock, AR 72205
Phone (501) 664-2174 Fax (501) 664-4236

PATIENT INFORMATION

Date:_____

First Name: _____ MI: _____ Last Name:_____

Age: ____ DOB: _____ SS# _____ Sex: ☐ M ☐ F Race: _____ Ethnicity _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Language: _____ Are you?: In a Nursing Home: ☐ Y ☐ N In Hospice: ☐ Y ☐ N

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

Employer Address _____

Spouse's Name _____ DOB _____ SS # _____

Spouse's Employer _____ Phone # _____

Spouse's Employers Address _____

Emergency Contact

Name _____ Phone # _____ Relation _____

Referring Physician _____

Primary Care Physician _____

Reason for Visit _____

Please list all other friends, relatives, or persons you give authority to contact us your behalf:

Name _____ Name _____

Name _____ Name _____

May we leave a message regarding test results and appointments on your answering machine? ☐ Y ☐ N

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INSURANCE INFORMATION

Patient Name _____ Date _____

Are you employed? □ Y □ N Place of Employment _____

If unemployed / retired, who was your la st employer? _____

Last day worked at previous job? _____

Work phone # _____ Last day of work _____

PRIMARY INSURANCE _____ PHONE _____

Insured Name _____ Birth Date _____

Policy ID # _____ Group # _____

Relationship of patient to policyholder _____

SECONDARY INSURANCE _____ PHONE _____

Insured Name _____ Birth Date _____

Policy ID # _____ Group # _____

Relationship of patient to policyholder _____

Do you have a prescription card? □ Y □ N If so, please present card to the receptionist to copy for our file.

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs, interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information, regarding my coverage to 'Blood and Cancer Institute of Little Rock'. I also authorize agents of any hospital treatment center or previous physicians to furnish 'Blood and Cancer Institute of Little Rock' copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accredidation agency, or any physician, or insurance carrier as needed. I also agree to a review of myrecords for purposes of internal audits, research and quality assurance reviews with 'Blood and Cancer Institute of Little Rock'
3. My right to payment for all pharmaceuticals, procedures, test, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned 'Blood and Cancer Institute of Little Rock'. This assignment covers any and all benefits under Medicare, other government sponsored programs,private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or ifpayments are made directly to me or my representative, I will endorse such payments to 'Blood and Cancer Institute of Little Rock'

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Consent for Evaluation and Treatment

I hereby authorize 'Blood and Cancer Institute of Little Rock'/Physician and their professional staff to provide the appropriate treatment and/or perform the necessary diagnostic tests / procedures / chemotherapy for my medical condition. I alsoconsent to hepatitis B and HIV testing, if needed, for the 'Blood and Cancer Institute of Little Rock'is to furnish information to insurance carriers, referringand primary physicians concerning my illness and all payments for medical services to myindependents or myself. I understand that at times it may be necessary for 'Blood and Cancer Institute of Little Rock'employees to contact me duringwork days while undergoing treatment. This may require that we leave you a message either at your work place or residence. I also understand that I am responsible for any amount not covered by my insurance. I agree to make payment on an every 30 day basis or as established by the billing office.

_____ _____

NamePatient Date

_____ _____

Patient Signature Date

Assignment of Benefits

I authorize payment by Medicare, Medicaid, or other insurance benefits be made on my behalf to 'Blood and Cancer Institute of Little Rock'. I authorize that all necessary medical and patient information be released to the Health Care Financing Administration to determine the benefits payable for these services.

_____ _____

NamePatient Date

_____ _____

Patient Signature Date

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Financial Policy

Dear Patient:

Thank you for choosing us to provide your health care needs.

The following statement represents our Financial Policy. We require that all patients, guardians, and/or responsible parties read and sign this agreement prior to treatment. It is the goal of this office to provide you with the best possible care. You can help us maintain this goal by keeping the agreement outlined below.

Medicare/Commercial Insurance Patients:

As a courtesy to you, we will file charges incurred with your insurance carrier. However, we do require co-pays, co-insurance and deductibles to be paid when services are rendered. Your portion will be calculated as accurately as possible but at best this is only an estimate. Any remaining balance following insurance payment is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.

Self-Pay Patients:

Full payment is due at the time of service for all patients without insurance. Special arrangements, when necessary may be made on an individual basis with one of our financial counselors.

Method of Payment:

For your convenience we accept cash, checks, money orders, Visa, Master Card and Discover. There will be a $27.00 service fee for all returned checks.

Medical Information Release:

I authorize release of any medical information necessary to process this claim and authorize payment of medical benefits to 'Blood and Cancer Institute of Little Rock'

I have thoroughly read this financial policy. I understand and agree to abide by the policy as stated above.

X _____ _____

Patient or Responsible Guardian's Signature Date

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Date _____

To Whom It May Concern:

This will be your authority and my request for you to release any and all reports and information which may be desired pertaining to any medical records under your supervision to:

Asif Masood, M.D.

Oncology/Hematology

_____ Medical Records

_____ X-rays, Scans/MRI Reports, etc.

_____ Pathology Slides/Blocks/Reports

_____ Laboratory Data

_____ Other

Name _____

Street _____

City _____

State _____ Zip Code _____

D.O.B. _____ SS # _____

Patient's Signature or Co-Signer

_____

Witness

_____

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Medication List

Patient Name _____

Date of Birth _____

Phone # _____

Pharmacy _____

Allergies

_____

_____

Date	Medication	Dose	Frequency