Physician (check one)

- Hoyt A. "Tres" Childs, M.D
- Ashlyn Everett, M.D.
- Elizabeth T. Falkenberg, M.D.
- John F. "Jack" Gleason, M.D.
- Harry J. "Jim" McCarty, M.D.
- Traci McCormick, M.D.

# Patient Registration

## Patient Information

Today's Date mm | dd | yy

| Referring Physician | | | City, State | |
|---|---|---|---|---|
| Last Name | First Name | MI | DOB mm / dd / yy | |
| Street Address | | | City, State, Zip | SS# |
| Home Phone Number | | | Cell Phone Number | |
| Marital Status (check one) Single Married Divorce Widow Separated | | | If married, spouse name | Spouse Phone Number |
| Initial (Permission granted to release any medical information to SPOUSE) | | | Are you currently employed? Yes No | If so, employer name: |
| Email Address | | | Patient Preferred Contact Method (Home Phone, Cell Phone, Email) | |
| In Case Of Emergency Contact (other than spouse) | | | Relationship | |
| Emergency Contact Phone Number | | | Initial (**Permission granted to release any medical information to Emergency Contact**) | |
| Do you have an advance directive? Yes No | If yes, please check the option that applies: Power of Attorney DNR Living Will Other ______ | | | |

## PATIENT DEMOGRAPHIC INFORMATION

Patient Preferred Language:
English Spanish Other ______

| Black or African American | Alaska Native | American Indian | Asian | Hispanic |
|---|---|---|---|---|
| Native Hawaiian | White | Other | Refused to Report/Unreported | |

## NOTICE OF PRIVACY PRACTICES

______________ (initial) I acknowledge that I have been made aware of the "Notice of Privacy Practices" posted by Alliance Cancer Care. This notice describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may request a copy of this notice at any time. I understand that I may contact the Privacy Officer at 256-319-5400 if I have a question, comment or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

## CONSENT TO HEALTHCARE COMMUNICATIONS

______________ (initial) I consent to receiving healthcare communications at the above listed numbers/email address for primary and alternative contact information for the purpose of appointment scheduling and reminders. I understand this includes voicemail messages.

| Patient Signature | Date |
|---|---|
| | |

## DISCLOSURES TO FAMILY MEMBERS AND/OR FRIENDS

I give permission for my Protected Health Information or Medical Records to be disclosed for the purposes of communicating results, findings and care decisions to the persons listed below.

| Name | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |

| Patient Signature | Date |
|---|---|
| | |

## INSURANCE INFORMATION

| Name Of Insurance Company | Phone Number |
|---|---|
| Policy Number | Group Number |
| Name Of Insured | Relationship (If Not Patient) |
| | |
| Name Of Insurance Company | Phone Number |
| Policy Number | Group Number |
| Name Of Insured | Relationship (If Not Patient) |

In consideration of services rendered and to be rendered, I hereby agree to pay and guarantee payment for all services rendered to me. I will pay when due whatever part is not covered by insurance. I further agree to pay charges which may be due by me for office visits at the conclusion of each visit. Should my account be referred to an attorney for collection, I agree to pay all reasonable attorney's fees and collection expenses as may be incurred.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my medical records to my insurance carriers, Healthcare Financing Administration, Medigap carriers, and/or such other persons or entities which may be responsible for my payment, in whole or in part. I hereby assign all medical benefits and payments to which I am entitled for services provided to me by Alliance Cancer Care to be paid to Alliance Cancer Care. More specifically, in the event I am entitled to any type of medical benefits arising out of a policy of insurance, said benefits are hereby assigned to Alliance Cancer Care, and/or any physicians acting on its behalf. I hereby agree that Alliance Cancer Care and/or any such physicians may receive any such payment.

| Patient Signature | Date |
|---|---|
| | |

**OFFICE ONLY**

REGISTRATION FORM SIGNED AND COMPLETE ________ RELEASE FORM SIGNED AND COMPLETE ________ INSURANCE CARD ________ DRIVER'S LICENSE_______

DOCUMENTS SCANNED INTO EMR ___________ FRONT OFFICE INITIAL __________

# AUTHORIZATION FOR USE, DISCLOSURE, AND REQUESTING OF PROTECTED HEALTH INFORMATION

## Patient Information

| Name Of Patient | | DOB mm / dd / yy |
|---|---|---|
| Address | City, State, Zip | |
| I hereby authorize ALLIANCE CANCER CARE to use, disclose, and request my protected health information as indicated below: | | |

### Purpose Of Disclosure:

Care and Treatment
Changing Physicians
At patient's request
Second Opinion
Other ______________________________

### Information To Be Released

From and To Dates ________________

Physical ExamNotes
Lab Reports
Radiology Reports
Other ______________________________

### Information To Be Requested

From and To Dates ________________

Physical ExamNotes
Lab Reports
Radiology Reports
Other ______________________________

I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.

I understand that I may revoke this authorization at any time by notifying Alliance Cancer Care's Privacy Officer at the address listed below, in writing, and this authorization will cease to be effective on the date notified except to the extent the action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other state of federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/ AIDS-related information, and psychiatric/mental health information.

My health care and payment for health care will not be affected if I do not sign this form.

I understand that I may request a copy of this form after I sign it.

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION**

| Patient Signature | Date | Signature of Authorized Person | Date |
|---|---|---|---|
| | | Relationship to Patient | |
| For Office Use Only | | | |
| Date Request Filled | | By | |