ALLIANCE CANCER CARE
RADIATION ONCOLOGY

PATIENT REGISTRATION

Today's Date: _____

Physician:

○ Hoyt A. "Tres" Childs III, M.D. ○ Ashlyn Seeley Everett, M.D. ○ Elizbeth T. Falkenberg, M.D. ○ John F. "Jack" Gleason Jr., M.D.
○ Harry J. "Jim" McCarty, III, M.D. ○ Traci C. McCormick, M.D. ○ Richard Pearlman, M.D. ○ Jefferson M. Trupp, M.D.

Referring Physician: _____ City, State: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Street Address: _____ City, State Zip: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

Email Address: _____ Patient Preferred Contact Method: ○ Home ○ Cell ○ Email

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

If married, spouse name: _____ Spouse Phone: _____

_____ (initial) **Permission granted to release any medical information to SPOUSE**

Are you currently employed? _____ If so, employer name: _____

Emergency Contact (other than spouse): _____ Relationship: _____

Emergency Contact Phone: _____

_____ (initial) **Permission granted to release any medical information to EMERGENCY CONTACT**

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 number(s)/email address(es) 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

PRIMARY INSURANCE:

Name of Insurance Company: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____ Relationship (If Not Patient): _____

SECONDARY INSURANCE:

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 USE ONLY

REGISTRATION FORM SIGNED AND COMPLETE _____ RELEASE FORM SIGNED AND COMPLETE _____ INSURANCE CARD _____ DRIVER'S LICENSE _____

DOCUMENTS SCANNED INTO EMR _____ FRONT OFFICE INITIALS _____