HUDSON VALLEY CANCER CENTER / Hudson Valley Hematology-Oncology Associates, RLLP

159 Barnegat Road	400 Westage Bus. Center Dr.	664 Stoneleigh Ave.	2649 Strang Blvd.	19 Bradhurst Ave.	400 East Main Street
Suite 101	Suite 103	Suite 202	Suite 208	Suite 2100	Mt. Kisco, NY 10549
Poughkeepsie, NY 12601	Fishkill, NY 12528	Carmel, NY 10512	Yorktown Hts., NY 10598	Hawthorne, NY 10598	
845-454-1942	845-896-8510	845-279-6282	914-245-6000	914-241-8866	914-241-8866

Last Name (print clearly) _____ **First Name** _____ **(M)** _____

_____/_____/_____ **Date of Birth** (____)_____-_____ **(H) Phone Number** (____)_____-_____ **(C) Phone Number**

Email address: _____ ***New Pt.*** _____ ***or Hospital Follow Up*** _____

( ) Male ( ) Female ( ) Single ( ) Married ( ) Widow ( ) Divorced

Address _____

City _____ **State** _____ **Zip** _____

Occupation _____ **Social Security #** _____/_____/_____

Employer _____ **Work Phone Number** _____

Ethnicity: Hispanic Non-hispanic – circle one **Preferred Language:** _____

Race: Caucasian Black Asian Am. Indian Hawaiian Other – CIRCLE ONE

Spouses Name _____ **Spouses date of Birth** _____/_____/_____

Spouses Social Security # _____/_____/_____

Primary Insurance _____ **Policy Number** _____

Group Number _____ **Name of the policy holder** _____

Relationship to patient _____

Name of someone to notify in case of an emergency _____

What is the relationship to you : _____ **Phone Number** _____

Secondary Insurance _____ **Policy Number** _____

Group Number _____ **Name of the policy holder** _____

Relationship to patient _____

Drug store name _____ Phone # _____

Name of your **primary physician** _____ Phone# _____

Referring physician if different than primary _____

Does your Insurance *REQUIRE* a specific laboratory to be used for lab work/specimens ? _____

(name of laboratory)

Do you have additional prescription coverage other than your above mentioned insurance? _____

GIVE PHARMACY CARD TO RECEPTIONIST

I authorize any holder of medical or other information about me to release to the health care financing administration or its intermediaries any information needed for completion of this or related Medicare claim. I permit a copy of this authorization to be used in place of the original. I also understand that I am responsible for acquiring referrals from my PCP and if I do not provide one at the time of my office visit, I will be personally and financially responsible for all charges incurred for all affected visits.

I hereby assign all medical benefits to which I am entitled including Medicare .private insurance, and third party payers to Hudson Valley Hematology Oncology Associates, RLLP. In the event I fail to notify HVHOA in a timely fashion of a change in my insurance, I will be personally and financially responsible for all charges incurred for all affected visits and monies owed. I under understand I am responsible for services not covered under my insurance contract.

Signature _____ Date _____

HUDSON VALLEY CANCER CENTER
Hudson Valley Hematology – Oncology Associates
AUTHORIZATION

Patient **Name:** _____ **DOB** _____
Patient Address _____ **Apt #** _____

_____, _____ _____
City **State** **Zip Code**

This authorization permits Hudson Valley Hematology-Oncology Associates to use or disclose my protected health information to the following third parties: physicians and others:
Please specify: _____

Information that will and may be used or disclosed is as follows: Names, addresses including street address, city, county, precinct, zip code, dates including birth date, admission date, discharge date, date of death,. All telephone numbers, fax numbers social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, medical records pertaining to my treatment to include all test results, MD consults and all information pertaining to your treatment .

Please list any information you **DO NOT** want disclosed:

_____

_____

This authorization will expire on (Date) _____

I understand that the information disclosed may be further disclosed by the above named entity. Third parties and may no longer be protected by the final privacy rule.

I understand that I may revoke this authorization in writing to the Hudson Valley Hematology Oncology Associates, ATTN: Chief Privacy Officer at 159 Barnegat Road, Suite 101, Poughkeepsie, NY 12601.

I understand that I have the right to refuse to sign this authorization and that my treatment, Payment for my healthcare benefits will not be affected if I do not sign this form.

Signed: _____ **Date:** _____

_____

Specify relationship to or authority to act for, Individual (if applicable)

_____

Print Name of individual or legal representative (if applicable)

_____

Signature of Legal Representative:

_____

PRIVACY NOTICE ACKNOWLEDGMENT
I, the undersigned, acknowledge that I have received, read and understand the Notice of Privacy Practice.

_____ **Date:** _____
Patient/Guardian Signature

Hudson Valley Hematology & Oncology Associates, RLLP

Notice of Privacy Practices Receipt Form

Patient Name: _____

Medical Record Number/Identification Number: _____

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices of Hudson Valley Hematology & Oncology Associates, RLLP which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information.

_____

Signature

_____ _____

Print Name Date

_____

Signature

Hudson Valley Hematology & Oncology Associates, RLLP

_____

Print Name

_____ _____

Title Date

HUDSON VALLEY CANCER CENTER

HUDSON VALLEY HEMATOLOGY ONCOLOGY ASSOCIATES, RLLP

REFERRAL, COPAYMENTS, PATIENT RESPONSBILITY and OFFICE POLICIES

REFERRALS
If your insurance company requires that you obtain a referral in advance of your visit, it is **your responsibility** to make sure you bring the referral with you or have it sent to us prior to your visit or get the referral number from your referring MD. We regret that we cannot call for you (emergency cases only).

DATE: _____ OFFICE LOCATION:_____ Patient Account Number_____

Patient Name: _____Contact #_____

INSURANCE PLAN: _____ID#_____

Referring MD/PCP:_____MD telephone_____

COPAYMENTS, COINSURANCES and other out of pocket expense
All copayments and other expenses are due at the time of service. If you are having a treatment, HVHOA will require a deposit at the time of service based on the information we received from you insurance company. If we have to bill for a copayment, you will be charged an additional $5.00 to cover our billing expense.

AFFORDABLE CARE PLANS – Individual plans
Any patient who has a monthly premium due for an individual plan **must bring proof of payment for that month** at the time of visit.

BOUNCED CHECK POLICY
HVHOA accepts checks as payment but if you bounce one check, you will be charged a 50.00 bounced check fee and we not be able to accept checks from you in the future. We will only accept cash, credit card or bank check.

MISSED APPOINTMENTS
It is the patient responsibility to cancel your appointments at least 24 hour in advance.

PATIENT AUTHORIZATION --I understand that if my health insurance company requires that I obtain a **REFERRAL** from my **Primary Care Physician (PCP)** prior to receiving medical services or treatment. If I do not provide Hudson Valley Hematology Oncology Associates with a referral as required by my insurance company, **I AGREE TO BE PERSONALLY AND FINANCIALLY REPSONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED** and to be treated as an out of network patient and **responsible for payment at the time of service.** ***This form is valid for ONE YEAR. Front Desk employee must witness and sign this form.
By signing this form I understand the referral, copayment, deductible and office policies of the practice.

SIGNED: _____DATE:_____

PRINT NAME: _____

WITNESS: _____DATE: _____

WITNESS PRINT NAME: _____

HUDSON VALLEY CANCER CENTER

HUDSON VALLEY HEMATOLOGY ONCOLOGY ASSOCIATES, RLLP

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

I hereby authorize Hudson Valley Hematology Oncology Associates, RLLP to leave/send detailed personal information by the following means: Check all that apply:

1. HVCC/HVHOA can contact me by email: _____
   CLEARLY WRITE EMAIL ADDRESS ABOVE

2 HVCC/HVHOA can leave a voicemail message on my: **MUST INITIAL/date**

   a. Home phone regarding: _____appointments _____medical information _____date
   b. Cell phone regarding: _____appointments _____medical information _____date
   c. Work phone regarding: _____appointments _____medical information _____date

2. HVCC/HVHOA can speak/leave a message with:

_____ (_____)_____ _____ ____ Appts. _____med info
name **telephone** **relationship** **check boxes**

_____ (_____)_____ _____ ____ Appts. _____med info
name **telephone** **relationship** **check boxes**

_____ (_____)_____ _____ ____ Appts. _____med info
name **telephone** **relationship** **check boxes**

3. HVCC/HVHOA can send mail to my home regarding: **MUST INITIAL/DATE**
   a. _____appointments _____medical information _____date

MY signature below, I acknowledge and understand that this information will be kept in my medical record. It is my responsibility to notify my healthcare provider should I change one or more of the above designations. I also acknowledge that with the authorizations of messages on voicemail that other people in my household or workplace may hear the personal health information left on a voice mail message.

DATE: _____ OFFICE LOCATION:_____ Patient Account Number_____

PATIENT NAME: _____ Date of Birth_____

SIGNED: _____DATE:_____

WITNESS: _____DATE: _____

WITNESS PRINT NAME: _____

***This form is valid for ONE YEAR. Front Desk employee must witness and sign this form.