

Date: _____

WIND RIVER ONCOLOGY

Patient Name: _____ Date of Birth: _____ M F

Social Security #: _____ S M W D Religion: _____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

Employer: _____

Emergency Contact: _____ Phone: () _____

Family Doctor: _____ Who referred you to us?: _____

Please list individuals we are authorized to speak with regarding your care/account: (Include the last four digits of their social security number or their mother's maiden name for verification purposes. Thank you.)

Name: _____ Last Four Digits of SS# or Mother's M.N.: _____

Name: _____ Last Four Digits of SS# or Mother's M.N.: _____

SPOUSE / PARENT / GUARDIAN / RESPONSIBLE PARTY:

Name: _____ Date of Birth: _____ M F
(REQUIRED)

Social Security #: _____ Address: _____

City/State: _____ Zip: _____ Home Phone: () _____

Employer: _____ Address: _____

City/State: _____ Zip: _____ Work Phone: () _____

INSURANCE INFORMATION (Primary) (PLEASE PROVIDE INSURANCE CARD FOR US TO COPY.)

Insurance Co.: _____ Address: _____

City/State: _____ Zip: _____ Insurance Co. Phone: () _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Group Name: _____

INSURANCE INFORMATION (Secondary)

Insurance Co.: _____ Address: _____

City/State: _____ Zip: _____ Insurance Co. Phone: () _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Group Name: _____

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. (PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT.) IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. Thank you.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to WIND RIVER ONCOLOGY for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

SIGNATURE: _____ DATE: _____