



# Tacoma/Valley Radiation Oncology Center

## Patients ~ Please complete the top portion of form:

Patient Name: \_\_\_\_\_ Hm Phone \_\_\_\_\_  
Last First Middle Initial Area Code & Telephone #

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status: \_\_\_\_\_ If married, spouse's name: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Employer \_\_\_\_\_ Wk Phone Number \_\_\_\_\_

Email Address: \_\_\_\_\_ May we contact you via email? \_\_\_\_\_

Alternate Person & Telephone Number: (If no one at your home) Are you under the care of Hospice? \_\_\_\_\_  
Are you in a Skilled Nursing Facility? \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Services are rendered to the patient, not an insurance company. The sole responsibility for payment of services is the patient and/or guardian.** I hereby assign to Tacoma/Valley Radiation Oncology Centers, all money from the insurance company to which I am entitled for expenses relative to services rendered by TROC/VROC. **In the event that I fail to acquire an authorization required by my insurance from the PCP of record, I am responsible for the charges incurred.**

I authorize Tacoma/Valley Radiation Oncology to use my Private Health Information, on my behalf, for purposes of planning and delivery of treatment, billing my insurance company, and internal health care operations.

I acknowledge receipt of the Tacoma/Valley Radiation Oncology Center Privacy Practice Policy.

Signature: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date: \_\_\_\_\_

A photo copy of this form shall be deemed as valid and as effective as the original

## Insurance / Verification Data – To be completed by the TROC/VROC staff

Identification Verified by: \_\_\_\_\_  
Staff Member \_\_\_\_\_ Date \_\_\_\_\_

Identification Document Type: Driver's License Number \_\_\_\_\_ Issue Date \_\_\_\_\_  
Passport Number \_\_\_\_\_ Issue Date \_\_\_\_\_

Plan Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_  
**Secondary –**

Plan Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Diagnosis ICD 9: \_\_\_\_\_ Description: \_\_\_\_\_

Assigned Physician: \_\_\_\_\_