TACOMA/VALLEY RADIATION ONCOLOGY CENTERS

Patient Name: _____
Last First Middle Initial

Home Phone: _____ Cell Phone: _____
Area code and Telephone # Area code and Telephone #

Address: _____
Street Apartment Number

City: _____ State: _____ Zip Code: _____

Email Address: _____ May we contact you via email? _____

Employer: _____Wk Phone Number: _____

Marital Status: _____ Spouse's name and number_____

Alternate Contact Person (relationship to patient) and phone #: _____

Patient's Date of Birth: _____ Social Security Number: _____ Gender: M F

Language: _____ Ethnicity (Please check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race (Please check one): ☐ African American ☐ Asian ☐ Caucasian ☐ Native American

☐ Pacific Islander ☐ Hispanic ☐ Other: _____

Preferred method of contact (home phone, cell, or email):_____

Are you under the care of Hospice? Y N Are you in a Skilled Nursing Facility? _____

Family Physician: _____Referring Physician: _____

Pharmacy of Choice: _____
Name Address or Intersection City/State/Zip

Insurance Information: Please fill out the following information regarding your insurance.

Primary Insurance	**Secondary Insurance**
Plan Name:	Plan Name:
Subscriber Name:	Subscriber Name:
ID Number: Group Number:	Subscriber SSN: Subscriber DOB:
Co-Pay Amount:	ID Number: Group Number:

How did you hear about us? Please circle:

Physician Friend Family Internet TV Radio Billboard
Other: _____

PLEASE TURN OVER

TACOMA/VALLEY RADIATION ONCOLOGY CENTERS

RE: Billing - Please read before signing:

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.

Signature: Relationship to Patient Date:

RE: Privacy Practices - Please read before signing.

Excerpt from Tacoma/Valley Radiation Oncology Center Privacy Practice Policy— Notification of Family and Others: While we treat your protected health information with utmost respect and concern for privacy, unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information.

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

Signature: Relationship to Patient Date:

If you object to protected health information being shared, please sign below:

Signature: Relationship to Patient Date:

This portion of the form is to be completed by the TVROC staff. Thank you!

Insurance / Verification Data –

Identification verified by: _____
Staff Member Date

Identification Document Type: Driver's License Number_____ Issue Date_____

Passport Number _____ Issue Date_____

Diagnosis Code: _____ Description: _____

Assigned Physician: _____

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

Rev 6/2015