WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER

Oncology Associates of Oregon

Assignment/Financial Responsibilities/Consent

Patient's Legal Name (Last, First MI)_____ Preferred Name _____

Social Security# _____ DOB _____ /_____/_____ Age _____

Billing Address_____ City_____ State_____ Zip _____

Street Address_____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Email _____ @ _____

Preferred Contact Method (circle): Cell Home Email Home Other **Preferred Language:** _____ **Sex:** M F

Marital Status (circle): Single Married Divorced Widow **Ethnicity:** _____ **Race:** _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Patient's Employer _____ Occupation _____ Retired _____ Disabled _____

Responsible Party _____ Relationship _____ Phone _____

Primary Insurance _____ Primary Insured Name _____ DOB _____

Primary Group Number_____ Primary Policy Number_____

Secondary Insurance _____ Secondary Insured Name _____ DOB _____

Secondary Group Number_____ Secondary Policy Number_____

Tertiary Insurance _____ Tertiary Insured Name _____ DOB _____

Tertiary Group Number_____ Tertiary Policy Number_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by WVCI, and I hereby assign to WVCI all assignable rights to payment for services rendered by WVCI, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by WVCI, other providers, and insurers for treatment, payment and health care operations purposes.

I understand that in order for WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that WVCI may request and use my prescription history from other healthcare provides or third party payors for treatment purposes as required by the above mentioned federal initiative. I authorize WVCI to obtain my prescription history.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

Print Name: _____
First MI Last

_____
Signature of Patient (for patients 17 years of age or younger, parent or guardian MUST sign) Date_____ /_____/_____

_____
If legal representative, provide relationship to patient Employee Initials_____

Last Revised Date: March 30, 2018

Oncology Associates of Oregon
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Preferred Pharmacy Information

Preferred Pharmacy _____ Phone _____

Prescription Plan Name _____ ID # _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Willamette Valley Cancer Institute's Notice of Privacy Practices.

Signature of Patient _____ Date_____ /_____/_____

_____

Signature of Patient (for patients 17 years of age or younger, parent or guardian MUST sign) Date_____ /_____/_____

Patient Consent for Practice to Communicate with Others

I authorize WVCI to speak with, and disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services. I understand that I can change this list at any time by notifying WVCI in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.

Which of the HIPAA Representatives noted below would you like to be your emergency contact person(s)? Please circle Y or N in the space provided below.

Name	Relationship to Patient	Phone Number	Emergency Contact? Y / N

I do ☐ I do not ☐ give permission to leave a detailed message on my answering machine or voicemail.

Patient Name (Printed)	Patient Signature	Date Signed
		_____ /_____/_____

Last Revised Date: March 30, 2018

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ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-541-683-5001.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-541-683-5001.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-541-683-5001.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-541-683-5001.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-541-683-5001.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-541-683-5001.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-541-683-5001.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-541-683-5001 まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم 1-5001-683-541) مقر .

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-541-683-5001.

ប្រយ័ត្ន៖ បើសិនអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈានសំបុត្រ គឺមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-541-683-5001.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-541-683-5001.

هجوت: رگا هب نابز یسراف وگتفگ م ینکی،د هستیتلا نابز یتروصب ارینگ ارب یامش مهارف م یدشاب اب 1-541-683-5001.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-541-683-5001.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-541-683-5001.

Last Revised Date: March 30, 2018