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## Assignment of Benefits

### Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Lady Lake Community Cancer Center** (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### HIPAA Receipt of Notice of Privacy Practices

My signature below indicates that I have received the HIPAA Notice of Privacy Practice and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Soc. Sec.# \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you live with someone else? Y N If so, with whom? \_\_\_\_\_

Name of Spouse: \_\_\_\_\_  
Address/Phone if different than your own \_\_\_\_\_

Do you live in Florida full time? Y N If no, when are you in Florida? \_\_\_\_\_

Other Residence: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Are you retired? Y N  
(if retired, your occupation prior to retirement)

Will you need transportation assistance to the Cancer Center? Y N

Do you have any financial concerns?  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Place of birth: \_\_\_\_\_ Where have you lived most of your life? \_\_\_\_\_

List anyone involved in your care: \_\_\_\_\_

Have you had radiation therapy before? \_\_\_\_\_ If yes, when, where, (city, state, name of facility) \_\_\_\_\_  
\_\_\_\_\_

Religious preference: \_\_\_\_\_

**Alcohol History:**

Do you drink beer, wine, or other alcohol products? \_\_\_\_\_ If so, what kind and how much? \_\_\_\_\_

Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_

**Tobacco History:**

Have you every used any tobacco products? \_\_\_\_\_

Please circle which ones:                      cigarettes                      pipe                      cigar                      chew                      snuff

Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_ Most used per day: \_\_\_\_\_

**Family History:**

Relation	Age	State of health	Cancer?	Cause of death	Age at death
Father					
Mother					
Spouse					
Brothers/Sisters					
Children					

Are you **ALLERGIC** to any medications, insects, or foods? Y N

If yes, which ones? \_\_\_\_\_

Have you ever had radiation therapy? Y N If yes, to what area(s) of your body, when, where, and how many treatments?

\_\_\_\_\_

Have you ever had chemotherapy? Y N If yes, what drugs, when, where, and how many treatments?

\_\_\_\_\_

Do you have, or have you ever had any of the following conditions/illnesses? If so, please specify.

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer (including skin cancers) _____ | <input type="checkbox"/> Diabetes _____                      |
| <input type="checkbox"/> Stroke _____                          | <input type="checkbox"/> Liver disease _____                 |
| <input type="checkbox"/> Migraines _____                       | <input type="checkbox"/> Gallstones _____                    |
| <input type="checkbox"/> Epilepsy _____                        | <input type="checkbox"/> Ulcer _____                         |
| <input type="checkbox"/> Mental illness _____                  | <input type="checkbox"/> Reflux disease _____                |
| <input type="checkbox"/> Vision Problems _____                 | <input type="checkbox"/> Lactose intolerance _____           |
| <input type="checkbox"/> Hearing problems _____                | <input type="checkbox"/> GI bleeding _____                   |
| <input type="checkbox"/> Thyroid problems _____                | <input type="checkbox"/> Hiatal hernia _____                 |
| <input type="checkbox"/> Mouth or throat problems _____        | <input type="checkbox"/> Hemorrhoids _____                   |
| <input type="checkbox"/> Seasonal allergies _____              | <input type="checkbox"/> Diverticulosis/Diverticulitis _____ |
| <input type="checkbox"/> Heart attack _____                    | <input type="checkbox"/> Irritable bowel _____               |
| <input type="checkbox"/> Angina _____                          | <input type="checkbox"/> Other bowel problems _____          |
| <input type="checkbox"/> Irregular heart beats _____           | <input type="checkbox"/> Kidney stones _____                 |
| <input type="checkbox"/> High blood pressure _____             | <input type="checkbox"/> Bladder infections _____            |
| <input type="checkbox"/> Congestive heart failure _____        | <input type="checkbox"/> Enlarged prostate _____             |
| <input type="checkbox"/> Pacemaker _____                       | <input type="checkbox"/> Prostatitis _____                   |
| <input type="checkbox"/> Free bleeding _____                   | <input type="checkbox"/> Prostate surgery _____              |
| <input type="checkbox"/> Anemia _____                          | <input type="checkbox"/> Female problems _____               |
| <input type="checkbox"/> Other blood disorders _____           | <input type="checkbox"/> Collagen disorders _____            |
| <input type="checkbox"/> Aneurysms _____                       | <input type="checkbox"/> Other autoimmune disorders _____    |
| <input type="checkbox"/> Emphysema _____                       | <input type="checkbox"/> Osteoporosis _____                  |
| <input type="checkbox"/> Chronic bronchitis _____              | <input type="checkbox"/> Osteoarthritis _____                |
| <input type="checkbox"/> Tuberculosis _____                    | <input type="checkbox"/> Rheumatoid arthritis _____          |
| <input type="checkbox"/> Asthma _____                          | <input type="checkbox"/> Bone problems _____                 |
| <input type="checkbox"/> Other lung problems _____             | <input type="checkbox"/> Fractures _____                     |
|  | <input type="checkbox"/> Muscle problems _____               |



Please list all surgeries, procedures, or hospitalizations you have had.

Type of surgery/procedure	When	Hospital/City/State

