MISSOURI CANCER ASSOCIATES

There for you, every step of the way.

Dear Patient:

Welcome to Missouri Cancer Associates! See enclosed appointment information with our facility in Columbia, MO.

Please complete the enclosed forms and bring them with you to your appointment along with your insurance cards. ***We will also need you to bring your current medication bottles to the appointment, including prescription and over-the-counter medications. If you have completed an advanced directive for healthcare of any kind, please bring a copy of that as well.***

Instructions for the demographic form:

1. Please fill out each line of the form.
2. For the emergency contact, please list either a family member or a friend that has a different phone number than you.
3. Sign and date the form on the second page.

Instructions for the Health Questionnaire:

1. Fill out all information regarding you and your family history.
2. Make sure and complete all pages.

Missouri Cancer Associates has knowledgeable and courteous Patient Benefit Representatives who will verify your insurance benefits prior to your appointment. Co-pays, deductibles and/or co-insurance amounts are expected on the date's services are provided. You will meet with a patient benefit representative on the day of your appointment for introductions and a tour of the office. Missouri Cancer Associates does offer financial assistance for patients who are in need. Please contact a Patient Benefit Representative with questions.

Please note that there is a $25 fee for all FMLA and disability forms requiring a physician/nurse to complete and sign.

Thank you for placing your trust in Missouri Cancer Associates. If you have any questions or concerns, you may contact our office at 573-874-7800 or toll free at 1-866-724-2413 and select "O" for the operator. You can also visit our website at www.missouricancer.com. We look forward to meeting you.

Sincerely,

MO Cancer Associates Team

MISSOURI CANCER ASSOCIATES

UROLOGY ASSOCIATES of Central Missouri

Legal Name_____ **Preferred Name**_____

Social Security#_____ **Date of Birth**_____/_____/_____

Marital Status (circle one): Single Married Divorced Separated Widow Other

Sex: Male Female **Preferred Language**_____

Race_____ **Ethnicity (circle one):** Not Hispanic/Latino Hispanic/Latino

Address_____ **City/State**_____ **Zip**_____

Home Phone _____ **Cell Ph**_____ **Wk Ph**_____

Email_____

Preferred Contact Method (circle one): Home phone Cell phone Work phone Email

Employment Status (circle one): Employed Unemployed Retired Other

Primary Care Physician_____ **Phone**_____

Preferred Pharmacy Information

Preferred Pharmacy _____ **Phone** _____

Insurance Policy Holder Information (complete if insurance is through spouse or parent)

Primary Insurance:

Name_____ **Date of Birth**_____ **SSN**_____

Address_____ **City/State**_____ **Zip**_____

Relationship_____ **Employer**_____

Secondary Insurance:

Name_____ **Date of Birth**_____ **SSN**_____

Address_____ **City/State**_____ **Zip**_____

Relationship_____ **Employer**_____

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 Missouri Cancer Associates and Urology Associates of Central MO for any services furnished to me by my provider. 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, responsible person(s) listed, Name of authorized person (specify relationship) or other healthcare providers assisting in my medical care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have been offered a copy of the Notice of Privacy Practices. We may share information through Carequality, a healthcare exchange, which is a provider portal for other providers involved in your care to have all the information necessary to diagnose and treat you.

CONSENT TO TREATMENT:

I authorize Missouri Cancer Associates/Urology Associates of Central MO and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of hepatitis A, B, C and HIV.

I understand that in order for Missouri Cancer Associates and Urology Associates of Central MO 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 Missouri Cancer Associates and Urology Associates of Central MO 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.

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 also understand and acknowledge that I am personally responsible to pay Missouri Cancer Associates and Urology Associates of Central MO in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

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

Print Name: _____ **DOB:** _____/_____/_____

_____ **Date:** _____/_____/_____

Signature of Patient or DPOA (For patients 17 yrs of age or younger, parent or guardian MUST sign.)

_____

If legal representative, relationship to patient

Emergency Contacts:

The patient above authorizes the disclosure of health and financial information to:

(This is not permission to release your official medical record)

Names_____**Phone**_____ **Relationship**_____

Names_____**Phone**_____ **Relationship**_____

Names_____**Phone**_____ **Relationship**_____