

Nearest Relative (Not living with you) Name _____

Relationship _____ Telephone (____) _____

Family Doctor (primary care) _____

Physician who referred you _____

Email Address: _____

Would you like to sign up for our patient portal? Yes No

Patient name: _____ Date: _____

PRIMARY INSURANCE

Insurance _____

Name of Insured _____

SS# _____

ID# _____ GRP# _____

Insured's Date of Birth _____

Insured's Employer _____

SECONDARY INSURANCE

Insurance _____

Name of Insured _____

SS# _____

ID# _____

Insured's Date of Birth _____

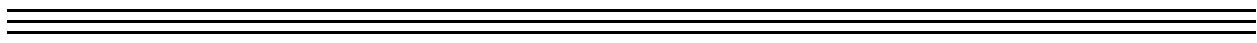
Insured's Employer _____

PHARMACY

Pharmacy Name _____

Address: _____
Street & City

Telephone _____



AUTHORIZATION TO PAY BENEFITS TO PROVIDER

Name of Insured: _____

I request that payment of authorized Medicare benefits and all Non-Medicare benefits be made either for me or on my behalf for services furnished me by Northwest Cancer Centers, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, and all other respective agents' information needed to determine these benefits or any benefits for related services. I understand that I am financially responsible to Northwest Cancer Centers for services not covered by my insurance policies.

Signature Insured/Representative/Legal Guardian Date

You will be provided our HIPAA privacy policy at the time of your appointment and will be asked to sign below at that time. I have received, read and understand the Notice of Privacy Practices.

Signature Insured/Representative/Legal Guardian Date

NORTHWEST CANCER CENTERS

Mohamad Kassar, M.D.
Anne Meier, M.D.
Shruti Singh, M.D.
Sameer Sharma, M.D.
George Sloan, M.D.
Gowri Ramadas, M.D.
Eduardo Braun, M.D.

Neel Shah, M.D.
Amer Sidani, M.D.
Michael Tallarico, M.D.
Peter Tothy, M.D.
Olusola Ogundipe, M.D.
Hubert Fornalik, M.D.

Medical Treatment Authorization Form

I grant my authorization and consent for Northwest Cancer Centers, and its affiliated physicians, nurse practitioners, nurses and other medical personnel to administer treatment while I am under their care.

I agree to assume financial responsibility for all expenses of portions of such care that are deemed patient responsibility under my current insurance plan. I agree to notify Northwest Cancer Centers of any changes in my insurance coverage.

It is understood that this authorization is given in advance of any medical treatments, and it is given to provide authority to my healthcare provider to exercise his or her best judgement in collaboration with myself and my family to deliver the best possible care for my condition.

Patient Signature _____

Date _____

Printed Name _____

Relationship _____

Witness _____

Date _____



Northwest Cancer Center

1001 Calumet Ave Dyer, IN 46311
1600 S. Lake Park Ave., Ste. 1101, Hobart, IN 46423
342 East 109th Ave. Crown Point, IN 46307
3800 St. Mary Dr. Ste. 302 Valparaiso, IN 46383
5510 Franklin Street Michigan City, IN 46360

Authorization to Release Medical Information

Patient Name _____ Soc. Sec. # _____
Address _____ Date of Birth _____
_____ Phone Number _____

I hereby Authorize and request you release information from my medical record to:

- | | |
|---|--|
| <input type="checkbox"/> Dr. Mohamad Kassar | <input type="checkbox"/> Dr. Michael Tallarico |
| <input type="checkbox"/> Dr. Anne Meier | <input type="checkbox"/> Dr. Amer Sidani |
| <input type="checkbox"/> Dr. Neel Shah | <input type="checkbox"/> Dr. Shruti Singh |
| <input type="checkbox"/> Dr. Sameer Sharma | <input type="checkbox"/> Dr. George Sloan |
| <input type="checkbox"/> Dr. Peter Tothy | <input type="checkbox"/> Dr. Olusola Ogundipe |
| <input type="checkbox"/> Dr. Gowri Ramadas | <input type="checkbox"/> Dr. Hubert Fornalik |
| <input type="checkbox"/> Dr. Eduardo Braun | <input type="checkbox"/> |

The Information to be released is from the time period From: ____ / ____ / ____
To: ____ / ____ / ____

HOSPITALIZATION

- Discharge Summary
- History and Physical
- Consultation
- Other (Specify)

OUTPATIENT VISITS

- Medical Summary
- History and Physical
- Consultation
- Lab Reports
- Diagnostic Reports
- Chemo Orders / Flowsheets

The complete history of record in your possession concerning my illness and/or treatment for the above –mentioned dates. I understand that the consent is revocable by me, in writing, at any time except to the extent the action has taken place in reliance on it. I also understand that this consent will expire either 60 days after the date of the signature or automatically when the records requested by this authorization have been sent to the requestor.

Signature _____ Date _____

Northwest Cancer Centers

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Northwest Cancer Centers are not required to agree to my requested restrictions, but if they do agree, then they are bound to abide by such restrictions.

Patient Name: _____ Signature: _____

Date: _____

I hereby authorize the delegated parties below to request and receive the release of my protected health information regarding my treatment, payment or administrative operations related to my treatment and payment. I understand that the identity of designated parties must be verified before the release of any of my information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office or notifying a member of the staff.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization, and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name: _____

Signature: _____

Date: _____

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Patient Financial Responsibility Statement

Thank you for choosing Northwest Cancer Centers as your healthcare provider. The medical services you seek imply an obligation on your part to ensure payment in full is made for services received. This Patient Financial Responsibility Statement will assist you in understanding your financial responsibility. Feel free to ask if you have any questions. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries the insurance, please share this statement with them, as it explains our policies regarding insurance billing, copayments, and patient billing. By your acknowledgement of this statement and/or by receipt of medical services from Northwest Cancer Center, you agree:

1. You acknowledge and agree to the FINANCIAL POLICIES OF Northwest Cancer Centers. If you have any questions about these policies, please contact the Billing Department. These policies may be changed by Northwest Cancer Center without notice.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for co-payments, which are due if applicable at the time of visit, deductibles and/or co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance. Should your bank return your payment due to insufficient funds, you will be charged a \$25 fee.
3. You are responsible for knowing your insurance policy and updating the office of any policy changes. For example, you will be responsible for any charges if any of the following apply: (1) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Northwest Cancer Centers, and you have not obtained such an authorization or referral; (2) you receive services in excess of such authorization or referral; (3) your health plan determines that the services you received at Northwest Cancer Center are not medically necessary and/or not covered by your insurance plan; (4) your health plan coverage has lapsed or expired at the time you receive services at Northwest Cancer Center; or (5) you have choose not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
4. You are responsible for a \$100 fee if it is your first visit to Northwest Cancer Centers and you do not show up to your appointment or you fail to cancel your appointment 24 hours prior to the scheduled visit.
5. Northwest Cancer Centers does not comply with white bagging or brown bagging policies mandated by insurance companies. White bagging is when a practice receives patient-specific drugs from a payer-mandated specialty pharmacy, to be stored in separate inventory prior to administration by the physicians. Brown bagging is when a payer requires a patient to acquire injectable drugs from a mandated vendor, then transport those drugs to their physician's office for administration. As your provider, we aim to make your safety our priority. Since such policies do not enable the practice to confirm pharmaceutical compliance from the distribution center to the practice, we will not participate in either of the policies.
6. NCC providers may order labs that require processing at an external lab including but not limited to: Bioreference, Quest or Hematogenix. It is your responsibility to cover any costs incurred if your insurance plan does not cover that cost.

Signature _____ Date _____

Print Name _____

Signature of Legal representative _____

Print Name of Legal representative _____