Compass Health

SETTING A NEW DIRECTION IN HEALTH CARE

2175 Coolidge Road

East Lansing, Michigan 48823

Patient Information for Radiation Oncology Consultation

Please complete this form prior to your consultation appointment with your Radiation Oncologist.

Patient Name: ____________________________ Date of Birth: __________ SSN: ____________________

Address: ____

Home Phone: _________________________ Cell Phone: ____________________ Sex: ☐ M ☐ F

Race: ☐ African American/ Black ☐ Asian ☐ Caucasian/White ☐ Greek ☐ Hispanic ☐ Indian ☐ Middle Eastern
☐ Native American Indian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Prefer Not to Answer

Preferred Language: ____________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Answer

Emergency Contact:	**Guarantor / Responsible Party:**
Name: ______________________________	Name: ______________________________
Relationship: ________________________	Relationship: ________________________
Address ____________________________	Address ____________________________
City: ____________ State: _____ Zip: _______	City: ____________ State: _____ Zip: _______
Phone: ______________________________	Phone: ______________________________

Primary Insurance: ________________________ ID#: ____________________ GRP: ___________

Subscribers Relationship to Patient: ☐ Self ☐ Spouse ☐ Other: ______________________________

Subscriber's Name: ______________________________ SSN#: ________________ DOB: _________

Subscriber's Employer: ____

Secomdary Insurance: ________________________ ID#: ____________________ GRP: ___________

Subscribers Relationship to Patient: ☐ Self ☐ Spouse ☐ Other: ______________________________

Subscriber's Name: ______________________________ SSN#: ________________ DOB: _________

Subscriber's Employer: ____

Patient Employer: ______________________________ Occupation: ______________________

Employer Address: ____________________________________ Work Phone: ________________

Advanced Directives: Please check all that apply: ☐ Living Will ☐ Do Not Resuscitate (DNR)
☐ Healthcare Proxy: Name and Phone Number of Healthcare Proxy: __________________________

If any are checked, please bring a copy with you to your consultation appointment.

Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Provider / Care Team Information

Patient Name: ________________________________ **Date of Birth:** __________

Referring Physician: ____

Address: ____

____

Phone: ______________________ Fax: ______________________

Primary Physician: ____

Address: ____

____

Phone: ______________________ Fax: ______________________

Medical Oncologist: ____

Address: ____

____

Phone: ______________________ Fax: ______________________

Surgeon: ____

Address: ____

____

Phone: ______________________ Fax: ______________________

How did you hear about us? ☐Physician ☐Family ☐ Friend ☐Website ☐ Advertisement ☐Other

Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Financial Responsibility Agreement

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visit(s) to Compass Healthcare, PLC. This includes medical services and visits, preventative exams and physicals, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make payment in full.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted / in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I agree to be financially responsible and make payment in full.

I understand and agree it is my responsibility to know if my Primary Care Physician (PCP) of choice has been processed by my insurance company or plan and if a referral is necessary from my PCP. If I have requested a PCP change that has not processed by my insurance company, it may result in claims being denied, and I agree to be financially responsible and make payment in full.

Patient/Guarantor Signature　　　　　　　　　　　　　　　　　　Today's Date

Patient/Guarantor Printed Name

Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Patient Disclosures & Consents

Assignment of Insurance Benefits

I hereby authorize direct payment of my insurance benefits to Compass Healthcare, PLC or the physician individually for the services rendered to my authorized dependents or me. I understand and agree that I will be responsible for any co-pay or balance due that Compass Healthcare, PLC is unable to collect from my insurance carrier. Initial: ______

Medicare/Medicaid/Champus Benefits

I certify that the information I have given by applying for payment under these programs is correct. I authorize the release of any of my records that these programs may request. I hereby direct that payment of y authorized benefits be made directly to Compass Healthcare, PLC. Initial: ______

Authorization to Release Non-Public Information

I hereby authorize Compass Healthcare, PLC or the physician to release medical or incidental, non-public, personal information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits. Initial: ______

Lab/X-Ray/Diagnostic Services

I understand that I may receive *a separate bill* from an entity (other than Compass Healthcare, PLC) if my medical care includes labs, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance.

Initial: ______

I hereby consent to evaluation, testing, and treatment as directed by my physician, and affirm that I have read and agree with all disclosures on this form.

____

Patient/Guarantor Signature Today's Date

____

Patient Printed Name

Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize Compass Healthcare, PLC to use and disclose my Protected Health Information (PHI) in the following manner:

Share my Protected Health Information with:
(Please CIRCLE and INITIAL applicable authorization)

__________ Spouse: Spouse's Name: ____

__________ Parent/siblings/child(ren)/guardian: Please provide applicable names: ___________

____

__________ The following person(s) ____

____

__________DO NOT DISCLOSE MY PHI WITH ANYONE

Disclose my protected health information for the following reasons:
(Please CIRCLE and INITIAL applicable authorization)

__________ To leave an appointment reminder on my answering machine/service
______at home ______at work

__________To leave a message on your answering machine to return a call
______at home ______at work

__________To leave a message with a family member/co-worker to return a call
______at home ______at work

__________DO NOT DISCLOSE MY PHI FOR ANY REASON STATED ABOVE

____

Patient/Guarantor Signature *Today's Date*