# Welcome…

**…**and thank you for choosing Champlain Valley Hematology Oncology (CVHO). Our mission is to provide the very best in comprehensive healthcare to our patients and we strive to provide that care in the most cost effective way. To help us maintain that excellent level of care we ask that you read the Financial Policy below and sign the attached patient information sheet in acknowledgement of your understanding and agreement to its terms. Please retain this for your records.

## FINANCIAL POLICY

We are participating providers with Medicare, Vermont Medicaid, Aetna, Blue Cross Blue Shield of Vermont, CBA, Cigna, MVP, United Health, and several group plans. Whether or not we are participating with your insurance company, we will submit insurance claim forms to them on your behalf. Please ask to speak with someone in our billing department if you have questions regarding an insurance plan that is not listed here. Co-payments are due upon check-in with our receptionist.

Individuals without insurance benefits, or insured patients with out-of-pocket responsibilities (such as deductibles, out-of-network cost sharing, co-insurance and/or co-pays) as dictated by his/her insurance company, will be personally responsible for the expenses incurred.

Available Payment Options:

☐ Cash ☐ Check ☐ Credit Card: American Express, Visa or MasterCard

Should your insurance carrier and/or policy change, please notify the CVHO billing department as soon as possible. It will be important for us to know when your previous policy was terminated and your new policy became effective. **Patients are responsible for notifying CVHO immediately of any changes to insurance coverage. Any charges that are denied payment due to failure of the patient to inform CVHO of changes in coverage will be forwarded to the patient for payment.**

If your financial situation prohibits payment by one of the options offered, we will be happy to refer you to a social worker, or patient assistance program. With prior-approval, we may be able to offer an individualized payment plan that fits your ability to pay.

Once a payment plan has been agreed upon, you will be expected to honor that agreement in good faith. It is the responsibility of every patient to make our billing department aware of any changes to his/her insurance status or financial situation.

Our billing specialists are available Monday-Friday 8:30 am to 5:00 pm to address any financial questions or concerns you may have.

## Patient Information **(*Indicates Fields That MUST Be Filled In)**

Date:_____ CVHO MRN: _____

*Name:_____ SSN:_____
Last First MI

*Date of Birth:_____ *Sex: ☐M ☐F *Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

*Mailing Address:_____

*Street Address (if different):_____

*Home Phone:_____ Cell:_____ Work:_____

*Patient Employer:_____ Occupation:_____

*Business Address:_____

*☐Retired Date:_____ *☐Disabled Date:_____

*Name of Spouse (First & Last):_____ *Best Contact Phone:_____

*Emergency Contact (First & Last):_____ *Best Contact Phone:_____

*Referring Physican:_____ *Primary Care Physician:_____

## Primary Medical Insurance **(Other Than Medicare)**

*Policy Holder's Name:_____
Last First MI

*Relationship to Patient:_____ *Date of Birth:_____ SSN:_____

*Address (if different from Patient's):_____ *Phone:_____

*Policy ID#:_____ *Group #:_____ *Subscriber/Member #:_____

## Additional Medical Insurance **Is Patient Covered by Additional Insurance? ☐ Yes ☐ No**

*Policy Holder's Name:_____
Last First MI

*Relationship to Patient:_____ *Date of Birth:_____ SSN:_____

*Address (if different from Patient's):_____ *Phone:_____

*Policy ID#:_____ *Group:_____ *Subscriber/Member #:_____

## Prescription Coverage/Insurance **Does the Patient Have Prescription Coverage? ☐ Yes ☐ No**

*Policy Holder's Name:_____
Last First MI

*Relationship to Patient:_____ *Date of Birth:_____ SSN:_____

*Address (if different from Patient's):_____ *Phone:_____

*Policy ID#:_____ *Group:_____ *Subscriber/Member #:_____

## Assignment and Release **(PLEASE READ CAREFULLY BEFORE SIGNING)**

**I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above and assign directly to Champlain Valley Hematology Oncology all insurance benefits, if any, for services rendered. I understand that I and my co-responsible party are financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that I do not have insurance, I understand that I and my co-responsible party are responsible for payment for services provided by Champlain Valley Hematology Oncology. I agree to seek a payment arrangement that meets my needs and that of Champlain Valley Hematology Oncology and to honor that arrangement in good faith. I acknowledge that I have received and read a copy of the Financial Policy of Champlain Valley Hematology Oncology and agree to its terms. I also acknowledge that I have received a copy of the Privacy Policy of Champlain Valley Hematology Oncology.**

_____ _____ _____
**Signature of Patient or Responsible Party** **Relationship to Patient** **Date**

_____ _____ _____
**Signature of Subscriber (If Not Patient)** **Relationship to Patient** **Date**

**MEDICARE INSURANCE**

MEDICARE BENEFICIARY'S LIFETIME ASSIGNMENT OF AUTHORIZATION
**(MEDICARE PATIENTS ONLY)**

_____
**Name of Beneficiary (Patient)**

_____
**Medicare ID Number**

Medicare Benefits Are: ☐Primary ☐Secondary

I request that payment of authorized Medicare Benefits be made to Champlain Valley Hematology Oncology for any services rendered to me by the physician(s)/provider(s) in this group. I authorize any holder of medical information about me or my case to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

_____ _____
**Signature of Patient/Beneficiary** **Date**

_____ _____
**Signature of Representative/Relationship** **Date**

****If you are a patient in a hospital, skilled nursing facility, or home, this authorization is in effect for the period of your confinement.**

****It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section I 128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.**

**HEALTH INFORMATION RELEASE**

**Patient Name:**_____ **DOB:**_____

I, _____, request that my medical records and/or radiology films and/or pathology slides be released to Dr. _____.

_____ _____
**Patient Signature** **Date**

_____ _____
**Responsible Party Signature/Relationship** **Date**

# MY MEDICATION LIST

*PATIENT INFORMATION*

Name: _____ DOB: _____/_____/_____

*PATIENT PROVIDERS*

| | Name | Phone |
|---|---|---|
| Pharmacy: | _____ | _____ |
| | _____ | _____ |
| Doctor(s): | _____ | _____ |
| | _____ | _____ |

***ALLERGIES:*** - Please list all allergies, including food and medication allergies, in the space below:

_____

**MEDICATIONS**

| MEDICATION NAME | STRENGTH/ DOSE | HOW DO YOU TAKE IT **Once a Day? Twice a Day? Other?** | PURPOSE **For what diagnosis?** | PRESCRIBED BY |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES OF CHAMPLAIN VALLEY HEMATOLOGY ONCOLOGY**

Patient Name:_____ CVHO MRN:_____

By signing below I acknowledge that I have received a copy of the notice of Privacy Practices of Champlain Valley Hematology Oncology.

_____
Print Name of Patient or Authorized Representative

_____
Signature of Patient or Authorized Representative

_____
Date

---

Description of Authorized Representative's Authority

Contact Information:

The contact information of the patient or personal representative who signed this form should be filled in below:

Address: _____

_____

_____

Daytime Telephone: _____

Evening Telephone: _____

***I, _____, grant permission to Champlain Valley Hematology Oncology and its representatives to share my Protected Health Information with the following parties. I understand that it is my responsibility to notify Champlain Valley Hematology Oncology that I wish to limit and/or revoke this permission and will not hold Champlain Valley Hematology Oncology liable for any information shared without my notification of such changes to this permission.****

_____ _____
**Name** **Relationship to Patient**

_____ _____
**Name** **Relationship to Patient**

_____ _____
**Name** **Relationship to Patient**

_____ _____
**Signature of Patient or Representative** **Date**