CANCER & BLOOD
SPECIALTY CLINIC

3851 KATELLA AVE
SUITE 125
LOS ALAMITOS, CA 92720
PHONE 562-735-0602
FAX 562-490-8590

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Last name: First: Mid:	Sex: ❑ M ❑ F	D.O.B / /	Marital status (circle one): Single / Mar / Div / Sep / Widow

Street address:	SSN:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no. : (____) _____

Mobile Phone: (____) _____	Home Phone: (____) _____	Email Address: _____

Which pharmacy (ies) do you use?

Pharmacy 1: _____ Phone: (____) _____ Location:_____

Pharmacy 2: _____ Phone: (____) _____ Location:_____

How did you hear about us? ❑ Referring Doctor ❑ Insurance Referral ❑ Family /Friends

❑ Website (list source):_____ ❑ Other

Ethnicity:	Preferred Language:	Race:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: (____) _____	Work phone no.: (____) _____

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he above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Current Medications

Medication	Dosage	Reason

Patient Name: _____ Date of Birth: _____

Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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Patient's Name: _____ Date of Birth: _____

Phone number: _____ Social Security #: _____

I request and authorize _____ to
(facility name)

release healthcare information of the patient named above to:

Name: *Cancer and Blood Specialty Clinic*

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other:

_____

I understand that I may refuse to sign this authorization or revoke this authorization at any time by giving written notice to Cancer and Blood Specialty Clinic. I understand that my revocation or refusal to sign this authorization form will not affect my ability to obtain health care services or payment or my eligibility for benefits. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand as a patient I have the right to access my records during business hours. Copies of the records may be obtained with reasonable notice and payment of printing cost. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effects as the original.

Signature: _____ Date:_____ Record Release Date: _____ Staff

Name:_____ Communication Preference:

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I authorize Cancer and Blood Specialty Clinic's staff to do the following:

- ❑ Leave a detailed messaged on my home phone: _____
- ❑ Leave a detailed message on my mobile phone: _____
- ❑ Leave a detailed message at the following phone number: _____
- ❑ Leave an email message at the following email: _____ Discuss and

❑ **release and share information regarding my health with the**

following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Acct #: _____

CANCER AND BLOOD SPECIALTY CLINIC appreciates the confidence you have shown in choosing us to provide for your medical care. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.
You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to CANCER AND BLOOD SPECIALTY CLINIC for providing medical care to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to CANCER AND BLOOD SPECIALTY CLINIC . I agree to pay CANCER AND BLOOD SPECIALTY CLINIC the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ Date: _____

Relationship to patient (i.e, self, guardian, etc.): _____

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Financial Fees of Practice

To our patients

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment. We understand that appointments may need to be rescheduled, but a courtesy call 24 hours in advance will allow us to accommodate another patient in that clinic time slot.

As such, the following fees have been instituted. These fees are not billable to your insurance and payment will be required prior to the next scheduled visit. If you have any questions, we are happy to discuss them with you.

THE FOLLOWING FEES WILL BE CHARGED:

Missed Appointments, no show without notice $ 25.00
Dictated Physician Letter $ 25.00
Forms-EDD, FMLA - $25
DMV, Jury Duty $10.00
Short Notice Cancellations $ 15.00
(Less than 24 hours' notice)
Non-Sufficient Funds Check $ 25.00

I understand that all fees listed above are NOT covered by insurance and must be paid in full prior to any new or rescheduled appointment or procedure.

I have read and understand the financial fees of the practice and I agree to be bound by its terms.

Signature_____ Printed Name_____

Date: _____

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Termination Policy:

The following are considered reasons to terminate a patient from Cancer and Blood Specialty Clinic:

1. Misuse/abuse of prescriptions and medications
2. An individual who fails to show for their first appointment without notification or rescheduling
3. The physician determines he/she cannot provide continued, effective care.
4. Threat of legal action against CBSC physicians and employees.
5. Chronically not showing for appointments
6. Failure of patient to comply with the physician's orders regarding the patient's care if that decision prevents the physician from providing adequate medical care
7. Discharge will be immediate for a threatening behavior or any implication of harm to any CBSC staff member

Every patient that is terminated from the care at CBSC will receive a written letter from the physician or designee stating the reason for termination.

Every effort will be made to provide ongoing health care to all patients at CBSC. This medical practice does not discriminate in providing care to a patient due to race, color, sex, religion, national origin, age, handicap, or any other factors prohibited by law. I have read and agree to abide by the above policy:

Print Name: _____ Signature: _____

Date:_____

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HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available on the government's Health and Human Services website: https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission for Cancer and Blood Specialty Clinic to send me personal health information via unencrypted email

Signature (parent or guardian if patient is a minor)	Date	Printed name	Please print email address
_____	_____	_____	_____

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

Signature (parent or guardian if patient is a minor)	Date	Printed name
_____	_____	_____

Please bring completed form to your visit

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