

Patient Name: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____
Last M.I. First

Birth Date: _____ Marital Status (Circle One): M S W D

Soc. Sec #: _____ Home Phone #: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse: _____

Other Contact Person: _____ Phone: _____

Family Members Living at Home: _____

Referring Physician: _____

Primary Care Physician: _____

Other Physicians involved in your care at this time: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I am aware of the Notice of Privacy Practice, which describes how medical information about me may be used and disclosed _____
(initial)

In consideration of the care of the above-name patient, the undersigned hereby consents to necessary treatment and promises to pay Nebraska Cancer Care, LLC, at current billing rates, sums for all obligations incurred for said patient by direction of the attending physician or representative of the patient. Upon request, an estimate of patient balance will be provided. The undersigned recognizes said sums cannot be accurately identified until the patient's treatment is complete, and it, therefore, is agreed the interim and final statements provide the patient for this treatment shall be considered a part of the promise to pay. Authority is given to release information requested by insurance companies and other pertaining to payment for services.

Your insurance company may have placed restrictions on your insurance coverage which must be satisfied prior to treatment. These restrictions could include pre-certification, referral and/or other requirements, Nebraska Cancer Care, LLC wants to be certain that you are aware of this. Fulfilling all insurance requirements prior to receiving care will result in maximum benefits for you.

I acknowledge that I am financially responsible for potentially non-covered services that my insurance plan may withhold. The insurance company may stipulate that certain goods, services or site of service are not necessary or reasonable under my plan limitations of care. If the insurance company denies the claim, my signature below acknowledges my agreement to be personally and fully responsible to pay Nebraska Cancer Care, LLC for these items and services.

Signature of Patient

Signature of Patient's Agent or Responsible Party

Date

Relationship to Patient