



WELCOME TO DESERT SPRINGS CANCER CARE

Thank you for choosing Desert Springs Cancer Care! We strive to provide the best possible medical care in the Valley. It is our pleasure to welcome you as a patient.

In order to give you the best care possible, it is the policy of this practice that new patients must have an initial consultation with the provider to discuss all lab and imaging results to properly plan a regimen fit for your condition. We thank you for actively participating in your care.

For your convenience, enclosed is our new patient paperwork. Please bring the completed paperwork to our office for your first visit. We also ask that you bring the following items:

- ✓ Insurance card(s)
- ✓ Photo ID
- ✓ Referral from your primary care physician (if needed)
- ✓ List of your prescription and non-prescription medications

Our office will be calling to confirm your appointment the business day before you are scheduled to arrive. Please call within 24 hours if you need to cancel or change your appointment time.

Sincerely,

Desert Springs Cancer Care



Desert Springs Cancer Care Acknowledgement of Privacy Notice

My signature below acknowledges that I am aware of Desert Springs Cancer Care's Privacy Notice (HIPAA Policies). I am aware that I am able to request a copy of the Privacy Notice for my own records.

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

_____ Date _____
(Patient/Guarantor Printed Name)

_____ Date _____
(Patient/Guarantor Signature)

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____ Witnessed by: _____

Internal use only:

If patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time) _____

By (name and title) _____

Desert Springs Cancer Care

Financial & Office Policies

Patient Name: _____ **DOB:** _____

Payment Policy:

Payment is expected at time of service. Your co-pay, coinsurance, and/or deductible are due at time of visit. For your convenience, we accept personal checks and most major credit cards. You will be responsible for payment of any remaining balances after insurance is billed.

Insurance Policy:

As one of your insurance companies' network providers we require your copayment in advance of your appointment. We also will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility. For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility. Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

Non-Covered Service Policy:

Certain services performed by our office are NOT COVERED by all insurance plans. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

Self Pay Services:

We provide a variety of services for our Self-Pay patients or patients that do not have any medical insurance coverage. Discount is based on 50% off our standard fee schedule which is available by request. Payment is expected at time of service.

Late Arrivals:

In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

Medical Records:

Should you request a copy of your medical records, please allow our office 7-10 business days for completion. There will be a \$25.00 charge for medical records which is expected at the time of completion. If you chose your records to be mailed to you an additional \$5.00 for US Priority Mail charges to track the envelope.

Forms Policy:

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of \$25.00 per form. Payment of this charge is expected at time of completion.

Desert Springs Cancer Care

Financial & Office Policies

Appointment Cancellations/No Shows/Reschedules:

There is a \$50.00 charge for Patients who no show for an appointment or cancel their scheduled appointment without giving 24 hours notice. These appointment times could have been given to another patient who needs medical care. We understand unusual circumstances may arise, please contact our office as soon as possible.

Prescriptions:

Appointments are required for medication refills. Please contact our office a minimum of 3 business days prior to your scheduled refill date. Phone call refills are not allowed.

Returned Checks:

Our office charges a \$35.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

Referrals & Authorizations:

If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

_____ Date _____
(Patient/Guarantor Printed Name)

_____ Date _____
(Patient/Guarantor Signature)



Health History Form

(Please Print)

Medical Conditions (current and previous):

Description	Age/Date Diagnosed

Allergies (or sensitivities) to medications or other substances? If so, list with type of reaction:

Current Medications and dosages(include over the counter medications):

Surgeries/hospitalizations (include year and reason):

Family History:

Mother:
Father:
Maternal grandmother:
Maternal grandfather:
Paternal grandmother:
Paternal grandfather:

Desert Springs Cancer Care
Patient Consent Form

Patient Name: _____

Date of Birth: _____

1. What number may we call you at?

() _____ - _____

() _____ - _____

() _____ - _____

2. May we leave a message on your voice mail or answering machine?

_____ (YES) _____ (NO)

3. Is there anyone other than yourself that you authorize us to speak with on behalf of your medical care? If so, please list below:

(Please print name)

(Relation to patient)

(Please print name)

(Relation to patient)

4. Do you have any other communication restrictions or authorizations that you would like to make known to us? If so, please list below:

I authorize Desert Springs Cancer Care to allow the person(s) listed above to pick up prescriptions or any order forms on my behalf, including medical records.

Signature

Date



Patient Registration Form

(Please Print)

Patient Information

Patient Name (Last, First, MI): _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Marital Status (circle one): Single / Married / Divorce / Sep / Widow / Sig Other Sex: M / F

Phone Number(s) Home: (____)____-____ Cell: (____)____-____

Email Address: _____ Would you like to receive our Newsletter: Yes / No

Referring Physician: _____ Phone Number: _____

Insurance Information

Primary Policy Holder's Name: _____ Date of Birth: _____

Insurance Carrier: _____ Group ID: _____

Individual ID#: _____ Co-Pay Amount: \$ _____

Secondary Policy Holder's Name: _____ Date of Birth: _____

Insurance Carrier: _____ Group ID: _____

Individual ID#: _____

Emergency Contact Name: _____ Relation: _____

Phone Number(s) Home: (____)____-____ Cell: (____)____-____

Address: _____

The information above 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 unpaid balance. I authorize Desert Springs Cancer Care, or any billing service and insurance company to release any information needed to process all claims. I am aware of HIPPA policies and Privacy Act of 1974.

Patient / Guardian Signature: _____ Date: _____



Desert Springs Cancer Care
Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security Number: _____

I request and authorize:

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Release healthcare information of the patient named above to:

Desert Springs Cancer Care
21803 N Scottsdale Road, Suite 110
Scottsdale, AZ 85255
Office: 480-585-4673 Fax: 480-585-4672

This request and authorization applies to:

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

All Healthcare information

_____ Date _____
(Patient/Guarantor Printed Name)

_____ Date _____
(Patient/Guarantor Signature)