

Please provide complete information for any additional insurance and/or cancer policies that you may have: _____

Does your Insurance Company require Precertification prior to hospitalization? Yes _____ No _____

Does your Insurance Company require a Co-Pay at time of visit? Yes _____ No _____ Amount of Co-Pay _____

Does your Insurance Company require a Co-Pay for Diagnostic Testing, X-Rays or Lab Services? Yes _____ No _____ Amount of Co-Pay _____

CONTACT PERSONS IN THE EVENT OF AN EMERGENCY: Please specify the person who we should contact in the event of an emergency:

Contact Person _____ Relationship to Patient _____

Address _____

(Include City, State & Zip)

Telephone: Work () _____ Home () _____ Other () _____

The physicians and staff of NOA hold a high regard for your privacy. However, occasionally it may be necessary and desirable for us to communicate with your family members, friends, or others involved in your care concerning your health information. Please specify with whom we may communicate other than you and the above listed contact person.

Please specify to whom we may **NOT** communicate:

COMMUNICATION OF HEALTH INFORMATION:

We will use appropriate means to communicate with you regarding your health information. Nevertheless certain communications (for example, leaving an appointment reminder message on your answering machine or with a family member) may result in the disclosure of your health information. Please specify below any restrictions on the ways in which we may communicate with you regarding your health information (for example, you may request that we communicate with you at your place of employment rather than at your home, by mail to a designated address or by phone to a designated phone number):

PLEASE COMPLETE THE FOLLOWING IF THE GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS TO NASHVILLE ONCOLOGY ASSOCIATES, PC IS SOMEONE OTHER THAN THE PATIENT:

Full Legal Name _____ Social Security Number _____

Address _____

(Include City, State & Zip)

Relationship to Patient _____ Occupation _____

Employer's Name & Address _____

(Include City, State & Zip)

Telephone: Work () _____ Home () _____ Other () _____

I hereby authorize NASHVILLE ONCOLOGY ASSOCIATES, PC as a holder of medical information to release to the Referring Physician, Family Physician and, any medical or medically related facility information regarding my diagnosis and treatment. I also authorize the release of medical information to my Insurance Carrier or its intermediaries information needed for this or any future related claim(s), and request that payment be made to NASHVILLE ONCOLOGY ASSOCIATES, PC / Karl M. Rogers, M.D. at P.O. Box 440267, Nashville, Tennessee 37244 or 2011 Church Street Suite 701, Nashville, Tennessee 37203. I further authorize NASHVILLE ONCOLOGY ASSOCIATES, PC to release my name and address to other parties for the sole purpose of receiving medically related information.

I understand I am financially responsible to NASHVILLE ONCOLOGY ASSOCIATES, PC / Karl M. Rogers, M.D. for all services regardless of any or all reimbursement paid by my Insurance Carrier. I further understand, if NASHVILLE ONCOLOGY ASSOCIATES, PC does not participate with my Insurance Plan that I will be responsible for all non-contractual amounts and fees over their insurance company's reimbursement fee schedule.

SIGNATURE _____ Date _____