MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

PATIENT CONFIDENTIAL INFORMATION

Patient Name _____ **Date**_____

Date of Birth _____ **Social Security #**_____ **Female** _____ **Male**_____

Email Address _____

Street Address _____ **City** _____ **ZIP** _____

Mailing Address _____**City** _____ **ZIP** _____

Home Phone Number _____ **Other Phone Number** _____

Name of Employer _____ **Occupation** _____

Employer's Address _____ **Phone Number** _____

Name of Spouse _____**Phone umber**_____

Spouse's Employer _____**Phone Number** _____

Nearest Friend or Relative _____**Relationship** _____

Address _____**Phone Number** _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

INSURANCE YES NO

Medicare # _____ **Medicaid #** _____

Other Insurance Name _____

Group # _____ **Policy #** _____

Name of Insured _____ **Relationship** _____

Preferred Pharmacy _____ **Pharmacy Location** _____

Preferred Hospital _____**Hospital Location** _____

Ethnicity _____**Hispanic or Latino** _____**Not Hispanic or Latino**

Preferred Language English / Spanish (Circle One)

Race ___**White** ___**African American** ___**Asian** ___**American Indian or Alaska Native** ___**Native Hawaiian** ___**Other**

RELEASE OF INFORMATION AND PAYMENT TO PHYSICIANS

In order to submit a claim for payment for covered services, we must have authorization to release medical information to your insurance carrier.

MEDICARE AND MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Mid Florida Hematology & Oncology Centers, P.A. to submit a claim to my insurance carrier or its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Mid Florida Hematology & Oncology Centers, P.A., Gregory L. Ortega, MD, Neeraj Sharma, MD, Rene Cabeza, MD, Bhanu Visvalingam, MD, and Santosh Nair, MD, Giselle Mery, MD, Seema Harichand, MD, Roderick Paras, MD, Gary Graham MD to use, disclose and furnish my personal health information, including but not limited to, information about the services rendered to me, as may be requested by my insurance carrier or its intermediaries, and to those providers of its treatment, payment, and health care operations and as described more fully in the Mid Florida Hematology & Oncology, P.A. written Notice of Privacy Practices which I have been provided a copy of.

I further agree that I am responsible for paying any balances which remain after insurance payments have been made.

Patient Signature_____ **Date** _____

Spouse Signature_____ **Date** _____

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