PATIENT INTAKE FORM
HOPE CANCER CLINIC, 14555 LEVAN RD., SUITE 110, LIVONIA, MI 48154.
PHONE: 734-462-2990. FAX: 734-462-3268.

Patient Name: (Last, First, Middle)		Social Security number:	
Street address,		Date of birth:	Sex ☐ M ☐ F
City		State	Zip
Home phone	Cell phone	Work phone	
Next of kin or emergency contact name and phone		Relationship to patient	

Primary Insurance ☐ Medicare ☐ Blue cross blue shield ☐ Other	Secondary Insurance ☐ Medicare ☐ Blue cross blue shield ☐ Other
Please give us copies of all of your insurance cards.	Employer name:
☐ HMO patients must have written referral: If you do not have an appropriate authorization each visit and/or treatment, the responsibility for the payment will be yours.	

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby request payment of authorized insurance benefits to be made to Hope Cancer Clinic for services
- provided to me. I authorize any holder of medical information about me to release any information necessary to determine these benefits or the benefits payable for related services. I authorize hope cancer clinic to release medical and other information to my insurance company for review of my coverage and/or for processing the claims for the services rendered to me.
- I authorize the release of any information to Hope cancer clinic as may be necessary for these purposes.
- I authorize Hope cancer clinic to review my insurance coverage with my insurance company.
- I authorize that a copy of this authorization form may be used in place of an original.
- I certify that to the best of my knowledge the information on this from is correct.

⇨ Patient Signature: ________________________________Today's date: _________________

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I received a copy of this office's notice of privacy practices.

Patient name ____

⇨ Patient Signature ____ Date: _______________

Name of the physician who sent you to us	Name of your primary physician
☐ No primary physician. ☐ Self referred.	☐ Referred by family or friend. ☐ Other

GENERAL CONSENT

1. I do hereby voluntarily consent to my care including examinations, tests, immunizations, vaccinations, regional or local anesthesia, routine procedures and other treatment by Hope cancer clinic professionals and its assistants or consultants as judged necessary in their judgment.
2. I understand that blood may be taken from me for HIV testing without my further permission if a doctor, other professional or an employee is exposed to my blood or bodily fluids.
3. If I do not understand any procedure or treatment or its risks or consequences, I have right to question appropriate health care personal.
4. I authorize the release to any party responsible for my care such information from my medical records as is required in order for Hope cancer clinic and all entities providing services to obtain payment. This includes records of alcohol/drug abuse and or treatment records indicated testing, diagnosis or treatment for HIV infection or related problems, records of psychological or social services including communication made by the patient to the physician, social worker or a psychologist. This authorization shall be necessary only so long as to obtain payment or reimbursement and will end when payment or reimbursement is received.
5. I understand that Hope cancer clinic is not liable for loss or damage to any personal property.
6. I understand the contents on this form and have read the form and my questions have been adequately answered prior to signing the form.

Patient Signature: ___________________________________Today's date: _________________

FINANCIAL POLICY

Full payment is due at the time of service. In order to bill to your insurance company it is necessary for you to bring in all insurance information. The balance of all visits and/or treatment is your responsibility. As a courtesy we will bill your insurance company. If insurance company has not paid your account in 90 days, the balance may be transferred to you for you for payment.

If your insurance is with an HMO or other managed care program, Hope cancer clinic will bill them only if you present an appropriate authorization form from them. You may be still responsible for any deductibles, co-pays or non-covered service. If you do not have an appropriate authorization each visit and/or treatment, the responsibility for the payment will be yours.

For those companies with whom our physicians do not participate, payment for the visit for the services is your responsibility.

I understand that if I default on payment for services, that my account may be transferred to an independent collection agency, designated as credit risk and payment for services will be required at the time of registration for all future visits.

I have read the financial policy as above. I understand and agree to above financial policy.

Signature: ___________________________________Today's date: _________________

FOR OFFICE USE ONLY: DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

Patient name ____ on _________________ (date), HCC office staff presented this acknowledgement of receipt of notice of privacy practices to above mentioned patient, who refused to provide a signature when requested.
Signature of office staff: ____