ALLIANCE
CANCER CENTER
Exceptional care. Close to home.

Acknowledgement of Receipt of Notice of Privacy Practices

With my signature below, I acknowledge receipt of the
Alliance Oncology
Notice of Privacy Practices

____
Name

X ____
Signature

____
If personal representative, please provide name and relationship to patient
(e.g. guardian, parent of child under 18)

____
Date

Medical Record Number ______________________________

Alliance Cancer Center – Greenville
1514 East Union Street
Greenville, MS 38703
P (662) 332-6150 **F** (662) 332-4558

Alliance Cancer Center – Clarksdale
581 Medical Drive
Clarksdale, MS 38614
P (662) 624-8731 **F** (662) 627-4674

www.Alliance-Greenville-Clarksdale.com

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Patient Name: ______________________________
MR #: ______________________________________
DOB: _______________________________________

Authorization to Release/Receive information

Your health information is protected by the "Health Insurance Portability and Accountability Act" (HIPAA) and as a result, we cannot discuss any personal information with family or friends unless you give us permission.

Please list the names of persons we are allowed to speak with and what relation they are to you. Please let them know, they must be able to verify you name, social security number, and birthday ***before*** any information may be released.

1. ________________________________ **Relation:** _________________**Phone#**_____________

2. ________________________________ **Relation:** _________________**Phone#**_____________

3. ________________________________ **Relation:** _________________**Phone#**_____________

4. ________________________________ **Relation:** _________________**Phone#**_____________

5. ________________________________ **Relation:** _________________**Phone#**_____________

If you have any questions, please see the "Notice of Privacy Practices" form or ask the office staff.

Thank you.

Patient's Name

Patient's Signature X ____ **Date** _________________

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MR #: ______________________________________
DOB: _______________________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

(A copy shall be valid as the original)

Please read the following information as it applies to you. During the course of radiation therapy treatments, you will receive a statement from Alliance Oncology for the services performed. We will file all insurance claims in our office and the insurance companies will send payments directly to us for our services provided to you. We will also file any secondary insurance if you have other coverage.

Some services may not be covered by your insurance for which you will be responsible; also, services are only covered as long as you are eligible according to your insurance plan.

We will accept the Medicare allowed amount for services, however; **Medicare pays 80%** of eligible charges, and **the patient is responsible for the remaining 20%,** unless you have a secondary insurance, which we will be glad to file for you. All other insurance's pay according to the plan you have during your eligible dates, **which may leave a balance for which you may be responsible.** If you have any questions regarding you plan, please call your insurance company. We want to help you understand our billing procedures and will be happy to assist you in any way we can. If you have any questions regarding your account with us, **please call our billing office at 1-877-451-4959.**

It is extremely important that you keep us informed of any changes in your insurance coverage as soon as possible.

MEDICARE

I authorize Alliance Oncology to release any information needed to the Social Security Administration or its intermediaries or carriers for the purpose of filing claims. I request that my insurance payments be made directly to Alliance Oncology for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

MEDICAID

I authorize Alliance Oncology to release any information needed to the Medicaid intermediary or carrier for the purpose of filing claims. I request that payment of benefits be made directly to Alliance Oncology. I acknowledge that I am financially responsible for any services provided on date for which I am not Medicaid eligible as well as any spend down amounts.

INSURANCE CARRIER

I authorize Alliance Oncology to release any information needed to my insurance carrier for the purpose of filing claims. I authorize the insurance payments be made directly to Alliance Oncology for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

X

Signature of patient or Authorized Representative | Relation to patient

Physicians Representative | Date Signed

Alliance Oncology does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs.

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Patient Name: ________________________
MR #: ______________________________
DOB: ______________________________

Patient's Name: ____ Date of Birth: ______________

Address: ____

I hereby authorize ____
Name of Physician, Facility or person

Located at ____
Street *City* *State* *Zip*

To release protected health information, contained in the medical record of the above-named patient to the following facility (circle):

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Information to be released:

Dates of Treatment to be Released: _________ to ___________

☒ Laboratory Result ☒ Imaging (Reports Only)

☒ Office Notes: ______________________________
Specify Clinician(s)

☒ Pathology ☒ Complete Record

☒ Other: ____

Purpose of Release: ☒ Medical Care ❑ Other: ____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

I understand that I may refuse to sign or revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above

X
____ ______________________
Signature of Patient or Authorized Representative Date

____ ______________________
Printed Name of Patient or Legal Representative Relationship to patient or authority to act for patient

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NOTICE OF PRIVACY RIGHTS & PRACTICES ACKNOWLEDGEMENT STATEMENT

We are required by a federal law known as “The Health Insurance Portability and Accountability Act” (HIPAA) as well as by Alabama law to maintain the privacy of your medical and health information, also referred to as “Protected Health Information” (PHI).

Our Notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the Notice (or any other Notice in effect at the time of the use or disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree to this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your Signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under Alabama law to the kinds of uses and disclosures of PHI mentioned in our Notice.

X Patient’s Signature: ___________________________________ Date: ________

Personal Representative: ________________________________ Date: ___________

Relationship to patient: ____

Signature of Interpreter: ________________________________

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