Premier Hematology-Oncology Care P.C.
1701 South Blvd E. Rochester Hills, MI 48307
Phone:248-243-3935 Fax: 248-243-3939

INSURANCE AGREEMENT

I authorize consent to the treatments deemed necessary by the physician/nurse, to the release of information necessary to process my medical claims. I authorize all payments to be made directly to PREMIER HEMATOLOGY ONCOLOGY CARE. This includes Blue Cross Blue Shield, Medicare, Medicaid, and all private insurance payments.
I, understand that I am responsible to procure for **all referrals** necessary from my primary care physician. If I fail to do so, I will be responsible for **all costs** incurred for treatment regardless of any contract or contacts, between the provider and insurance company. I understand that I am financially responsible for all non-covered services including those not covered due to failure to provide referrals (HMO), and that co-pays and deductibles are my responsibility. I understand that I am financially responsible for all Medicaid charges, if applicable.

_____ _____

Signature **Date**

GENERAL CONSENT FOR TREATMENT

I freely consent to medical care by the doctors and their designees of Premier Hematology- Oncology Care P.C. I understand that by consenting I agree to give **all** information about my illness and factors that may contribute to or alter the course of the illness. I also understand that such information constitutes part of my medical record and will be charted and maintained as a permanent document with the doctors and their designees. Such records are a property of the practice. I am, hereby, also advised that I have the right to obtain a copy of such records on written request. I also consent to **all** necessary physical examination by the doctors and their designees. I also understand that I may be asked to undergo, treatments/tests/transfusions/ procedures, etc., that are determined to be necessary by my doctor as part of my medical care and I consent to the same. I understand that this consent to medical care will be considered as valid indefinitely from my first medical encounter with the practice. I am also, hereby, advised that I have the right to withdraw this consent at any time.

_____ _____

Signature **Date**

RECORD REALEASE AUTHORIZATION/ASSIGNMENT OF BENEFITS

I hereby authorize Premier Hematology- Oncology Care P.C., to release complete or partial records in their possession regarding my illness and/ or treatment to Medicare/ my private insurance company/ any agency that pertains to payment. I hereby authorize assignment of benefits from Medicare/my insurance company/ agency claims to be remitted directly to Premier Hematology-Oncology Care P.C. I understand that Premier Hematology- Oncology Care P.C. has the right to release any or all records to legal representation in the case of a legal claim of litigation.

I understand that I will be responsible for any unpaid balance that Medicare/ my private insurance agency/carrier does not cover. I also understand that it is mandatory that I notify my health care provider of any party/parties that may be responsible for paying for services rendered. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

_____ _____

Signature **Date**

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CANCELLATION, NO SHOW and LATE POLICY

Premier Hematology-Oncology Care P.C. is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (248) 243-3935 at least 24 hours **prior** to your scheduled appointment (or sooner) to notify us of any changes or cancellations.

Infusion appointments which are cancelled with less than 24 hours notification of your appointment may be subject to a $75.00 cancellation fee. Cancellations (includes injections, iron infusions, immunotherapy infusions, and phlebotomies) made without 24 hours in advance notification may be subject to a $75.00 cancellation fee. This fee may be applied if medication has already been mixed for your treatment. With medication being prepped for your treatment, it **cannot** be reused for another patient and results in the medication being discarded.

Late Arrivals for appointments with the physician: If a patient presents to the office **15 minutes** late for a scheduled office visit with our providers, the patient **will be rescheduled.** This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers in the best manner possible but **cannot** compromise on the quality and timely care provided to our other patients.

No-Show patients*:* Patients who do not show up for their infusion appointment without calling to cancel the appointment will be considered as **NO SHOW**. No-showing an infusion appointment may result in a $100 fee. This fee may be applied if medication has already been mixed for your treatment. With medication being prepped for your treatment, it **cannot** be reused for another patient and results in the medication being discarded. Patients who No-Show **three (3) consecutive** times for an infusion appointment in a **12-month period**, may no longer be able to schedule infusions in office but will have an order placed to schedule at Beaumont Infusion Center.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but **only with management approval**. Our practice firmly believes that a good physician/patient relationship is based upon understanding and trust. At PHOC P.C. we expect our patients to have ownership and responsibility of their healthcare needs and this means communicating cancellations. As a courtesy, we will call you to confirm your appointments on the Tuesday or Friday prior to your appointment date. Please understand that it is your responsibility to remember your appointment dates and times to avoid late arrivals, missed appointments and the cancellation fee. Please sign that you have read, understand and agree to this Cancellation and No-show Policy.

Patient Name (Please Print) and date: _____

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HIPAA

HIPAA requires Health care providers to protect the privacy of your health information. However, if you don't object, a health care provider may share relevant information with family members or friends involved in your health care in certain circumstances. This will include verbal communication with providers and staff, and allows them to pick up prescriptions, medical supplies, requesting copies of your medical records, finding out appointment dates and times, and other health care supplies on your behalf.

These family and friends are Not to be considered as emergency contacts. The family members and friends listed below are involved in my care and can access information from my providers and staff.

I understand I have the right to change my mind and revoke access to any of the listed family or friends listed below.

I allow my health care providers and their staff to share relevant information with the following listed family members or friends involved in my care.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Printed Name **Date of Birth**

Patient Signature **Today's Date**

ANY FAMILY MEMBER OR FRIEND NOT LISTED ON THIS FORM IS RESTRICTED FROM ANY RIGHT TO ACCESS MY HEALTH INFORMATION.

Check this box ONLY if it applies to you:

☐ **I do NOT have anyone that I would like to be able to retrieve my health information.**

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Code Status Form

We have found that it is helpful to know a patient's decision regarding resuscitation well in advance of the need for such information. Please indicate your wishes on the form below and sign and date at the bottom. Your doctor will discuss this decision with you. It is also important that you let your family members know your wishes. This will help ease their minds during an emergency.

Please keep in mind that this form does not apply to hospital stays. This form is only associated with our office when you are in our care.

Check the Appropriate Choice:

_____**Full Resuscitation** - (Full Code))- meaning in the event of a heart attack, allergic reaction, or incidental fall, you would like the following:

-CPR

-Defibrillation

-Drugs

_____**Do Not Resuscitate** -(No Code)- meaning in the event of a heart attack, allergic reaction, or incidental fall, you would NOT like to be resuscitated.

_____ _____

(Date) (Patient's Signature)

_____ _____

(Date) (Physician or Nurse Practitioner Signature)

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A Patient-Centered Medical Home is a Partnership Between the Patient and his/her Physicians

Being a part of a Patient-Centered Medical Home, your Primary Care Physician will:

- Work with you to improve your health
- Review your medications at every visit and recommend changes if needed
- Develop a plan with you to improve your health and manage any chronic health problems
- Set health goals with you and monitor your progress to help you stay healthy
- Use computer technology as needed to optimize your care
- Inform you of all test results in a timely manner
- Provide you with educational material and information about community programs that will help you improve your health
- Provide 24 hour phone access to a medically trained professional (doctor, nurse or other provider)
- Work with after-hours care centers to be informed of your visit within 24 hours
- Offer same day appointments when needed

By choosing to participate in a Patient-Centered Medical Home, I agree to:

- Make sure my doctor knows my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Follow my doctor's recommendations
- Frequently sign into my patient medical record portal to update my medical history, review messages, and communicate with my provider(s) when necessary
- Ask my doctor questions about things I do not understand
- Ask my Primary Care Physician for advice before making an appointment with a specialist
- Ask other health care providers to send my doctor information such as lab or test results, x-rays, or treatment notes
- Understand my insurance, what it covers and update the office with changes
- Provide the office feedback on how they can improve my care

Being a part of a Patient-Centered Medical Home Neighborhood, your Specialists will:

- Communicate with your Primary Care Physician about treatment plans, medications, test orders and test results
- Support the treatment plans and health goals set by your Primary Care Physician
- Have an agreement with your Primary Care Physician regarding who will have the lead responsibility for your care if a chronic disease exists
- Have same day appointments available for urgent problems and appointments within 1-3 weeks available depending on your medical needs
- Work with your Primary Care Physician to coordinate all aspects of your care

Patient Signature: _____

Date: _____

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