Central Coast Oncology & Hematology

Amy McMullen, MD Michael Yen, MD PhD

Patient Demographics and Insurance

Legal Name (Last, First, Middle Initial)			
Preferred Name			
Gender (assigned at birth)	Pronoun (He, She, They)	Date of Birth	SSN
Address		City, State	Zip code
Phone (Home/Cell)		Email	
Contact Preference (Please circle one) Home Cell Both		Marital Status	Employer
Race (please circle OR underline) American Indian/Alaskan Native Asian Indian Black/African American Chinese Filipino Japanese Korean Native Hawaiian Other Pacific Islander Prefer Not to Answer Samoan Vietnamese White/Caucasian		Hispanic Origin (please circle OR underline) Cuban Mexican Non-Hispanic Other Hispanic/Latino/Spanish origin Prefer Not to Answer Puerto Rican	
Language Preference (please circle) English Spanish Other: _____		Special accommodations requested:	
Primary Care Provider		Provider that referred you to our office	
Emergency Contact Name (Last, First) & phone number		Relationship to your emergency contact	
Primary Insurance plan		Member ID #	
Secondary Insurance plan		Member ID #	
Tertiary Insurance plan		Member ID #	

Signature: _____ Date: _____

1669 Dominican Way Santa Cruz, CA 95065 Phone (831) 475-2220 Fax (831) 472-2221

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Consent to Treat

I consent to any examination or procedure rendered to me under the instructions of my physician. I recognize the physicians furnishing services to me are independent agents.

Initial_____

Assignment of Benefits to Physician

I hereby give authorization for payment of insurance benefits to be made directly to Central Coast Oncology & Hematology for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Our Managed Care patients will be responsible for all non-covered services as outlined by their plan. In the event of a default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Central Coast Oncology & Hematology to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Initial _____

Notice to Patients of Open Payment Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

Initial _____

For Medicare patients only: Medicare Authorization to Pay Benefits to Physician

I request that payment of authorized Medicare benefits be made to me or on my behalf to Central Coast Oncology & Hematology for any services furnished to me. I authorize the holder of medical information about me to release the Centers of Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Personal Representative