Willamette Valley Cancer Institute and Research Center
Oncology Associates of Oregon
Assignment/Financial Responsibilities/Consent

Patient's Legal Name (Last, First MI)_____ Preferred Name _____

Social Security# _____ DOB _____/_____/_____ Age _____

Billing Address_____ City_____ State_____ Zip _____

Street Address_____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Email _____ @ _____

Preferred Contact Method (circle): Cell Home Email Other **Preferred Language:** _____ **Sex:** M F

Marital Status (circle): Single Married Divorced Widow **Ethnicity:** _____ **Race:** _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Patient's Employer _____ Occupation _____ Retired _____ Disabled _____

Responsible Party _____ Relationship _____ Phone _____

Primary Insurance _____ Primary Insured Name _____ DOB _____

Primary Group Number_____ Primary Policy Number_____

Secondary Insurance _____ Secondary Insured Name _____ DOB _____

Secondary Group Number_____ Secondary Policy Number_____

Tertiary Insurance _____ Tertiary Insured Name _____ DOB _____

Tertiary Group Number_____ Tertiary Policy Number_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by WVCI, and I hereby assign to WVCI all assignable rights to payment for services rendered by WVCI, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by WVCI, other providers, and insurers for treatment, payment and health care operations purposes.

I understand that in order for WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that WVCI may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize WVCI to obtain my prescription history.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

Print Name: _____
First MI Last

_____
Signature of Patient (for patients 17 years of age or younger, parent or guardian MUST sign) Date_____/_____/_____

_____
If legal representative, provide relationship to patient Employee Initials: _____

Last Revised Date: January 28, 2020

Willamette Valley Cancer Institute and Research Center
Oncology Associates of Oregon

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Willamette Valley Cancer Institute and Research Center (WVCI) has a responsibility to protect the privacy of your health care information. **WVCI** also has a responsibility to give a Notice of Privacy Practices that describes:

- how your health care info may be used and shared
- how you can get your health care info
- and whom to reach if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time. You may call WVCI at 541-683-5001 or check our website to get an up-to-date copy of the notice or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Willamette Valley Cancer Institute and Research Center.

_____

Patient Legal Name – First, Middle Initial, Last

_____ _____

Signature of Patient or *Personal Representative Date Time

***If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:**

_____ _____ _____

Name of Personal Representative Relationship to Patient Phone Number

This form will be retained in your records.

For Internal Use Only

Willamette Valley Cancer Institute and Research Center

If acknowledgement was **not** obtained, please state the reason:

_____

_____

WVCI Employee _____ _____

Printed name Signature

Last Revised Date: January 28, 2020

Willamette Valley Cancer Institute and Research Center (WVCI)

PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

Print Patient's Legal Name – First, Middle Initial, Last **Date of Birth**

Phone Number (Home/Cell) **Phone Number (Work)**

1. Alternate Contact Information Authorization

WVCI has my Authorization to:	Leave medical information on my home/cell voicemail	Y	N
	Contact me at my place of employment	Y	N
	Leave medical information on voicemail at my place of employment	Y	N

2. Family / Friends Release of Information Authorization

I authorize WVCI to speak with, and disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services.

Name	Relationship to Patient	Phone Number	Y / N Emergency Contact?
			Y / N
			Y / N
			Y / N
			Y / N

3. Surrogate Decision Maker

If I am unable to make healthcare decisions for myself my surrogate decision maker is named below and WVCI can contact this individual in case of an emergency.

Name of Health Care Surrogate Decision Maker	Relationship to Patient	Phone Number

4. Validation and Signature

I understand that I can change this list at any time by notifying WVCI in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.

Signature of Patient Date

***If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:**

Name of Personal Representative Relationship to Patient