NORTHWEST CANCER CENTERS

Mohamad Kassar, M.D.
Anne Meier, M.D.
Shruti Singh, M.D.
Sameer Sharma, M.D.
Peter Tothy, M.D.
Gowri Ramadas, M.D.
Rozina Chowdhery, M.D.
Neel Shah, M.D.
Amer Sidani, M.D.
Michael Tallarico, M.D.
Rajul Kothari, M.D.
George Sloan, M.D.
Olusola Ogundipe, M.D.

PATIENT INFORMATION

Patient Name ____ ☐ Male ☐ Female
Last First Middle

Date of Birth _________________ Age _____ Social Security ______ - ____ - _______

Address ____

Telephone (________) __________________ Cell Phone (_____) ______________________

Email Address: ____

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse Name ___________________________

Patient's Employer ______________ Phone (___) ______________ ☐ Retired ☐ Active

Preferred Language ________________________

Race (Please circle one.)

American Indian or Alaska Native
Asian
Black or African American
Unreported/Refuse to report
Caucasian
Latino
Other

Ethnicity (Please circle one.)

Hispanic or Latino
Non-Hispanic or Latino
Unknown

Nearest Relative (Not living with you) Name ______________________________

Relationship ____________________ Telephone ( ) ____________________

Family Doctor (primary care) ______________________________

Physician who referred you ______________________________

Email Address: ______________________________

Would you like to sign up for our patient portal? ☐ Ask the front desk for more information.

Patient name: ____________________ Date: ____________________

PRIMARY INSURANCE

Insurance ____________________

Name of Insured ____________________

SS# ____________________

ID# __________ GRP# __________

Insured's Date of Birth ____________________

Insured's Employer ____________________

SECONDARY INSURANCE

Insurance ____________________

Name of Insured ____________________

SS# ____________________

ID# ____________________

Insured's Date of Birth ____________________

Insured's Employer ____________________

PHARMACY

Pharmacy Name ____________________

ID# ____________________

Telephone ____________________

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

Name of Insured: ______________________________

I request that payment of authorized Medicare benefits and all Non-Medicare benefits be made either rot me or on my behalf for services furnished me by Northwest Cancer Center, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, and all other respective agents' information needed to determine these benefits or any benefits for related services. I understand that I am financially responsible to Northwest Cancer Center for services not covered by my insurance policies.

____

Signature Insured/Representative/Legal Guardian Date

You will be provided our HIPAA privacy policy at the time of your appointment and will be sked to sign below at that time. I have received, read and understand the Notice of Privacy Practices.

____

Signature Insured/Representative/Legal Guardian Date

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health records. As the patient, you are in control of your Portal record: We will not activate your personal account unless you authorize us to do so. Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others. If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand that you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust. If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal. The terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

____
Patient name (First name, middle initial, last name)

____
Email Address of Patient/Authorized User

____
Date of Birth of Patient

____
Physician's Name

Authorized User Is:
□ Patient
□ Patient's Designee

____
Patient's Designee's Name (Printed)

____
Patient's Designee's Signature

____
Patient's Signature

____
Date

____
Signature of Practice Staff (confirming user's identity and authority)

____
Date

Note to self: Accept this form only when the identity and authority of the signing person has been confirmed and the signing person (i.e., the patient's designee) understands and agrees to use the listed email address for this purpose. Please make a copy for the patient.

Staff use only: Patient MRN: ________________

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Medical Treatment Authorization Form

I grant my authorization and consent for Northwest Oncology, P.C., and its affiliated physicians, nurse practitioners, nurses and other medical personnel to administer treatment while I am under their care.

I agree to assume financial responsibility for all expenses of portions of such care that are deemed patient responsibility under my current insurance plan. I agree to notify Northwest Oncology, P.C. of any changes in my insurance coverage.

It is understood that this authorization is given in advance of any medical treatments, and it is given to provide authority to my healthcare provider to exercise his or her best judgement in collaboration with myself and my family to deliver the best possible care for my condition.

Patient Signature ______________________________ Date ______________________________

Printed Name ______________________________ Relationship ______________________________

Witness ______________________________ Date ______________________________

Northwest
CANCER CENTER

MEDICATIONS

Patient name: ______________________________ Allergies: __________________

Pharmacy name, location & phone # ____

DATE	MEDICATIONS	DOSE	FREQUENCY	TIMES TAKEN

Northwest Cancer Center
1001 Calumet Ave Dyer, IN 46311
1600 S. Lake Park Ave., Ste. 1101, Hobart, IN 46423
342 East 109th Ave. Crown Point, IN 46307
3800 St. Mary Dr. Ste. 302 Valparaiso, IN 46383
5510 Franklin Street Michigan City, 46360

Authorization to Release Medical Information

Patient Name_________________________________ Soc. Sec. #________________________

Address _____________________________________ Date of Birth______________________

_____________________________________ Phone Number ____________________

I hereby Authorize and request you release information from my medical record to:

□ **Dr. Mohamad Kassar**

□ **Dr. Anne Meier**

□ **Dr. Neel Shah**

□ **Dr. Sameer Sharma**

□ **Dr. Peter Tothy**

□ **Dr. Gowri Ramadas**

□ **Dr. Rozina Chowdhery**

□ **Dr. Michael Tallarico**

□ **Dr. Amer Sidani**

□ **Dr. Shruti Singh**

□ **Dr. Rajul Kothari**

□ **Dr. George Sloan**

□ **Dr. Olusola Ogundipe**

The Information to be released is from the time period From: _____ / ______ / ______

To: ______ / _______ /_______

HOSPITALIZATION

_______ Discharge Summary

_______ History and Physical

_______Consultation

_______ Other (Specify)

OUTPATIENT VISITS

_______ Medical Summary

_______ History and Physical

_______Consultation

_______Lab Reports

_______ Diagnostic Reports

_______Chemo Orders / Flowsheets

The complete history of record in your possession concerning my illness and/or treatment for the above –mention dates.
I understand that the consent is revocable by me, in writing, at any time except to the extent the action has taken place in reliance on it. I also understand that this consent will expire either 60 days after the date of the signature or automatically when the records requested by this authorization have been sent to the requestor.

Signature_______________________________________ **Date**___________________

Northwest Cancer Centers

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ______________________________ Signature: ___________________________

____

I hereby authorize the delegated parties below to request and receive the release of my protected health information regarding my treatment, payment or administrative operations related to my treatment and payment. I understand that the identity of designated parties must be verified before the release of any of my information.

Name: ___________________________________ Relationship: _________________________

Name: ___________________________________ Relationship: _________________________

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office or notifying a member of the staff.
- Information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization, and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.

Patient Name: ________________________________

Signature: ___________________________________

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Patient Financial Responsibility Statement

Thank you for choosing Northwest Cancer Center as your healthcare provider. The medical services you seek imply an obligation on your part to ensure payment in full is made for services received. This Patient Financial Responsibility Statement will assist you in understanding your financial responsibility. Feel free to ask if you have any questions. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries the insurance, please share this statement with them, as it explains our policies regarding insurance billing, copayments, and patient billing. By your acknowledgement of this statement and/or by receipt of medical services from Northwest Cancer Center, you agree:

1. You acknowledge and agree to the FINANCIAL POLICIES OF Northwest Cancer Center. If you have any questions about these policies, please address the Billing Department. These policies may be changed by Northwest Cancer Center without notice.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for co-payments, which are due if applicable at the time of visit, deductibles and/or co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance. Should your bank return your payment due to insufficient funds, you will be charged a $25 fee.
3. You are responsible for knowing your insurance policy and updating the office of any policy changes. For example, you will be responsible for any charges if any of the following apply: (1) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Northwest Cancer Center, and you have not obtained such an authorization or referral; (2) you receive services in excess of such authorization or referral; (3) your health plan determines that the services you received at Northwest Cancer Center are not medically necessary and/or not covered by your insurance plan; (4) your health plan coverage has lapsed or expired at the time you receive services at Northwest Cancer Center; or (5) you have choose not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
4. You are responsible for a $100 fee if it is your first visit to Northwest Cancer Center and you do not show up to your appointment or you fail to cancel your appointment 24 hours prior to the scheduled visit.
5. Northwest Cancer Center does not comply with white bagging or brown bagging policies mandated by insurance companies. White bagging is when a practice receives patient-specific drugs from a payer-mandated specialty pharmacy, to be stored in separate inventory prior to administration by the physicians. Brown bagging is when a payer requires a patient to acquire injectable drugs from a mandated vendor, then transport those drugs to their physician's office for administration. As your provider, we aim to make your safety our priority. Since such policies do not enable the practice to confirm pharmaceutical compliance from the distribution center to the practice, we will not participate in either of the policies.

Signature ______________________________________ Date __________________________________

Print Name ____________________________________

Signature of Legal representative ____

Print Name of Legal representative ____