Follow Up Form

CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

NAME: **Date of Birth:** **EMAIL:**	**Preferred Contact Number (Please Check): _____Home _____ Cell** **HOME #:** **CELL #:**
Address: □No Change	**City/State/Zip:**

INSURANCE INFORMATION:

Primary: _____ Member ID:_____ Group: _____

Subscriber Name:_____

Secondary:_____ Member ID:_____ Group:_____

Subscriber Name:_____

Spouse Name:_____ Spouse DOB:_____

Spouse Employer:_____ Phone:_____

CURRENT MEDS: □NO CHANGE

PREFERRED PHARMACY: NAME: LOCATION: PHONE:

ALLERGIES: □NO CHANGE

PRIMARY CARE PHYSICIAN:

LIST OF ANY OTHER PHYSICIANS PRESENTLY SEEING OR HAVE SEEN SINCE LAST VISIT:

RECENT SURGERIES OR HOSPITALIZATIONS SINCE LAST VISIT:

HAVE YOU HAD ANY RECENT SCANS OR PROCEDURES DONE SINCE LAST VISIT? □ Yes □No
IF YES, LIST TYPE OF SCAN/PROCEDURE, DATE, AND FACILITY

HAVE YOU EVER HAD A COLONOSCOPY? □ Yes □No IF YES, DATE OF PROCEDURE?

DO YOU CURRENTLY SMOKE □ Yes □No IF YES, HOW MUCH PER DAY?

IF MALE, LIST DATE OF LAST PSA:

IF FEMALE, LIST DATE OF LAST MAMMOGRAM: LAST PAP SMEAR:

DO YOU HAVE A LIVING WILL? □ Yes □No

REVIEW OF SYSTEMS (symptoms within last two weeks) (circle all that apply)

Poor Appetite	Hair Loss	Bloody Vomit	Muscle Weakness
Fatigue	Increased Skin Sensitivity to Sun	Rectal Bleeding	Range of Motion
Fever	Hives/Itching/Rash	Hemorrhoids	Describe _____
Night Sweats	Breast Masses	Black Tarry Stools	Disorientation/Confusion
Weight Change	Nipple Discharge	Nausea	Dizziness
Blurred vision	Nipple Inversion	Abdominal Pain/Cramping	Difficulty Walking
Double Vision	Breast Pain	Vomiting	Headaches
Visual Difficulties	Heart Racing	Burning in Urination	Nerve Pain/Neuropathy
Difficulty Swallowing	Chest Pain	Frequent Urination	Seizure
Impaired Hearing	Swelling to feet and legs	Blood in Urine	Anxiety
Hoarseness	Cough	Impaired Sex Function/Impotent	Hallucinations
Mouth Dryness	Shortness of Breath	Loss of Bladder/Bowel	Depression
Oral Bleeding	Coughing up Blood	Waking at Night to Urinate	Diabetes
Mouth Sores	Chest Pain upon Breathing	Urine Urgency	Hot Flashes
Neck Pain	Wheezing	Vaginal Discharge/Bleeding	Thyroid Disease
Swelling in Neck	Constipation	Bone Pain	Easy Bruising
Blisters on Skin	Diarrhea	Joint Pain	Swollen Lymph Nodes
Other: _____			

I attest that all of the information in this document is true, correct to the best of my knowledge, and understand that my physician will base his opinions and judgements on the same.

_____ _____

Patient Signature **Date**

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As our patient, we care about you and want to help you understand our billing process. Please take a moment to become familiar with the services provided by the Business Office staff at the Central Alabama Radiation Oncology, LLC. Representatives are available Monday – Friday from 8:00am – 5:00pm to facilitate inquiries.

Health Insurance

Central Alabama Radiation Oncology, LLC participates with most major insurance companies, such as Medicare and Medicaid. Prior to your visit, check with your employer or insurance company to see if you have access to health care services at Central Alabama Radiation Oncology, LLC, otherwise you may be responsible for all or a large portion of your health care services. Bring all of your health insurance information when you register. This includes your insurance cards which will provide the name of your insurance company, group number, and plan number. We will bill the primary insurance carrier for your healthcare services, and if applicable, your secondary insurance company as a courtesy. It is important to remember that health insurance coverage varies and some services may not be covered. If you have questions regarding your health insurance coverage, please call ***your insurance carrier*** to better understand how ***your policy*** works prior to receiving care at Central Alabama Radiation Oncology, LLC.

Information Update

It is ***your responsibility*** to inform us of any insurance or personal data change. Incorrect information can cause payment delays or denials that may ultimately leave you responsible for payment.

Co-Payments & Deductibles

Co-payments and other balances are due ***on the day you receive services***. If your insurance carrier requires it, you will need to pay for estimated coinsurance or deductibles related to the services provided. If you have any questions regarding co-payments or deductibles, please call your insurance carrier for policy guidelines.

Non-Covered Services

If your insurance carrier disagrees with our Provider that the service provided was not medically necessary, is a pre-existing condition, or is a non-covered service, you may be asked to sign a notice that makes you financially responsible for the services provided and you will be asked to pay at the time of service.

Patient Statements

In the event your insurance carrier does not pay the entire bill, we will send you a statement to notify you of any remaining unpaid balances. This statement will usually arrive within 45 days of receiving services at Central Alabama Radiation Oncology, LLC unless there is a delay in your insurance carrier's payment. Your insurance company may be billed for services covered by another physician in our facility if your doctor was not available for your treatment. For your convenience, we accept cash, checks, and all major credit cards including Visa, Master Card, and Discover. ***Payment is due 15 days after you receive a statement***. Please tell us if you are unable to pay your bill in full. We are available to assist you with monthly payment plans.

Collection Process

Central Alabama Radiation Oncology, LLC will use the services of ***Holloway Credit Solutions*** in collection of all outstanding debt. Accounts which are not paid within 90 days, and for which NO special arrangements have been made, will be subject to placement with ***Holloway Credit Solution.*** If your account is placed for collection, you agree to be responsible for paying all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Consent to contact patient

You agree, in order for us to service your account or collect monies you may owe, Central Alabama Radiation Oncology, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Central Alabama Radiation Oncology, LLC, its employees and/or agents may contact me/us as described above.

_____ _____

Patient Signature **Date**

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Patient Name:	**Date of Birth:**

I hereby authorize **Central Alabama Radiation Oncology** to use, disclose and/or obtain my health information for continuation of medical care.

By providing this Authorization, I understand as follows:

(1) I understand that I will receive a copy of the authorization form after I sign it.
(2) I understand that the health information may be subject to re-disclosure by the recipient of the health information. In the case of re-disclosure, such health information may no longer be protected by HIPAA privacy rules.
(3) I understand that if I refuse to sign this authorization my treatment and/ or payment obligations do not change. While signing this authorization is voluntary, refusal to do so may slow the disclosure of records with any appropriate health or payment institution that requires a signed authorization through internal requirements.
(4) I understand that revocation of this authorization may be done by me at any time in writing by notifying the Compliance Officer at Central Alabama Radiation Oncology, LLC, 4143 Carmichael Road, Montgomery, AL, 36106. Should I do so, I understand this will not have any effect on uses or disclosures prior to the receipt of the revocation.

Medical Records use only:

Specific description of the health information to be used/disclosed/obtained:

_____

_____

_____

_____

_____ _____

Patient Signature **Date**