

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 Employer _____

Insurance Customer Ph# _____

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 to 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 asked 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: _____

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 Ogunlope, M.D.

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

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
2600 Roosevelt Road 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:

- | | |
|---|--|
| <input type="checkbox"/> Dr. Mohamad Kassar | <input type="checkbox"/> Dr. Michael Tallarico |
| <input type="checkbox"/> Dr. Anne Meier | <input type="checkbox"/> Dr. Amer Sidani |
| <input type="checkbox"/> Dr. Neel Shah | <input type="checkbox"/> Dr. Shruti Singh |
| <input type="checkbox"/> Dr. Sameer Sharma | <input type="checkbox"/> Dr. Rajul Kothari |
| <input type="checkbox"/> Dr. Peter Tothy | <input type="checkbox"/> Dr. George Sloan |
| <input type="checkbox"/> Dr. Gowri Ramadas | <input type="checkbox"/> Dr. Olusola Ogundipe |
| <input type="checkbox"/> Dr. Rozina Chowdhery | |

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-disclosure 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: _____

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 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 Oncology, P.C. 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.
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.

Signature _____ Date _____

Print Name _____

Signature of Legal representative _____

Print Name of Legal representative _____