HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK, P.C.

PATIENT DEMOGRAPHICS
Please Print and use only BLUE or BLACK Ink

Last_____ _____ **First**_____ **M**_____ **DOB** _____/_____/_____

Maiden/Other Name _____ **Marital Status**_____ **Sex:** ☐Male ☐Female

Home Address: _____**City**_____ **ST**_____ **Zip**_____ - _____

County_____ **Social security Number**: _____/_____/_____

Home Phone: (_____) _____-_____ **Cell Phone: (_____)** _____-_____ Email_____

Occupation:_____ ☐ Check if we can send our newsletter by email

Patient Employer: _____ **Work Phone**_____ **Retired**? ☐Yes ☐No

Patient work address: _____**City**_____ **ST**_____ **Zip**_____

Spouse/Relative: _____ **Spouse DOB**_____/_____/_____ **Spouse SS#**_____-_____-_____

Spouse Address: _____**City**_____ **ST**_____ **Zip**_____

Spouse Employer: _____**Spouse Work Phone**_____ **Retired**? ☐Yes ☐No

Spouse Employer Address_____**City**_____**ST**_____**Zip**_____

Emergency Contact: _____ **Emergency Phone**_____

Emergency Address: _____**City**_____ **ST**_____ **Zip**_____

Care Giver Primary:_____ **Relation:**_____ **Phone**_____

Referring MD/Phone_____ **Primary Care Provider/Phone**_____

Please Indicate Preferred Pharmacy: _____ **Phone:** _____

Pharmacy Address/Location_____

Insurance Information

☐**Please check if you have No insurance**

Medicare:
Recipient ID#_____ Hosp. Coverage Effective date_____ Med. Coverage effective date_____
Blue Shield:
Policy Holder Name_____ Relation to Pt _____ ID#_____
Group #_____ Coverage Type_____ Employer name_____ Effective date_____
Medicaid:
Recipient ID #_____ Coverage Code_____ County_____
Other Insurance:
Insured person_____ID#_____Ins Co Address_____
Disabled/Retired Disabled/Retired from_____ (Company) Date last Worked_____
(Circle One)

Medicare Only: I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim. I request that payment under the medical insurance program be made to Hematology Oncology Assoc. of CNY for services performed to me indefinitely.

Signature_____ Date_____

All Patients: I hereby authorize Hematology-Oncology Associates of CNY to release any medical information concerning or relating to my health assessment or treatment to insurance companies and other third-party payers, health care providers and suppliers, pharmaceutical assistance programs, and state and federal agencies in connection with my health care or to secure payment for services or items furnished to me. I hereby authorize insurance companies and other third-party payers, including Medicare, to make payment of benefits directly to Hematology-Oncology Associates of CNY.

Signature_____ Date_____

HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK, P.C.
5008 Brittonfield Parkway, East Syracuse, NY 13057
Phone 315-472-7504 Fax 315-634-5168

Contact and Medical Release Authorization Form

I, ___________________________DOB____________________, am a patient at Hematology Oncology Associates of CNY, P.C.,

I authorize all staff to contact me by the following methods:

Home phone _______________________ May leave a message? Yes ______ No ______

Cell phone __________________________ May leave a message? Yes ______ No ______

Work phone_________________________ May leave a message? Yes ______ No ______

Please list order of calling Preferences: 1.___________ 2.______________ 3.________________

I authorize physicians, nurses and other health care professionals involved in my care to disclose information regarding my care to the following Authorized Family and Friends

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_____________

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_____________

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_________

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

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Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_____________

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_____________

Print Name______________________________________ **Relationship**_________________________ **Phone**________________

Include: ☐Alcohol/Drug Treatment ☐Mental health treatment **Voicemail**_____________

Alcohol/Drug Treatment and Mental Health treatment records will only be released to the listed individuals if the patient has chosen to disclose this information by selecting the box.

I understand that I may revoke this consent at any time, except to the extent that the disclosure has already been made. I may make additions or deletions to the form. Changes can be made by completing another form. I understand that no information will be given to any family member or caretaker who is not listed on this form.

____

Patient Signature / Authorized Representative Date

HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK

Insurance / Billing
Frequently Asked Questions

- *What is a co-pay and when do I need to pay it?*

  A co-pay is a payment set by the insurance plan on a specific medical service to be paid at the time the service is rendered. Co-pays are fixed dollar amounts and typically do not apply to the out-of-pocket maximum (the collective amount in which must be satisfied to access 100 percent coverage for the remainder of the calendar year).

- *Why am I being charged more than one co-pay per visit?*

  Many insurance plans will apply more than one co-pay per day on services requiring co-pays. To determine if your plan does, you can reference your insurance benefits sheet given by our Intake Team or contact your insurance directly. If your insurance plan only allows one co-pay per day, per provider, please contact our Billing Department.

- *What is a co-insurance and when do I need to pay it?*

  Co-insurance is a percentage of the insurance's allowed amount for a specific service, due after the claim has been processed. Co-insurances are typically applied after satisfying a deductible and apply to an annual out-of-pocket max.

- *What is a deductible and when do I need to pay it?*

  A deductible is the annual amount that must be paid out-of-pocket before the insurance will cover specific services. Typically, deductibles apply at the beginning of the calendar year and are due when you receive your statement.

- *Why am I being billed for an amount my secondary insurance should have paid?*

  The most common reason is that many secondary insurance plans do not cover the primary insurance's annual deductible. Another reason could be that there is not a benefit for the particular service received. If you feel that your secondary insurance should have paid and has not, please contact our billing department.

- *Which amount on my statement do I need to pay; the "total balance" or the "pay this amount"?*

  The amount specified next to "please pay this amount" is the amount due when the statement was received and is the only amount you should pay.

- *Can I pay my bill over the phone with a credit card?*

  Yes. The Billing Department can process your payment over the phone at (315) 234-2812.

- *What is the maximum amount of time from the date of service that Hematology/Oncology Assoc. of CNY can bill the remaining balance after insurance has paid?*

  Under New York State Law, balances can be billed for as many as six years, however, if you are initially being billed for a date of service that occurred over a year ago please contact the Billing Department. There are multiple reasons why there can be long delays from the date of service to the time a bill is received for the balance. Often, the delays are attributed to insurance

Contact Information	
Billing Department	(315) 234-2812
Budget Plan Arrangements / Collections	(315) 472-7504 ext. 1079

HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK

Financial Agreement

Name	Birth Date (MM/DD/YYYY)

Payments	Explanation	Payment Due
Co-pays	Set dollar amount applied to certain services by insurance contract. Under some policies, multiple co-pays can apply per day. Typically, co-pays do not apply to an out-of-pocket maximum.	Each visit at the front desk
Co-insurance	Percentage of the allowed amount that is the patient's responsibility. Amount is set by insurance contract for certain services.	Upon receipt of statement
Deductible	Fixed amount that must be paid by the patient at the beginning of the year before benefits can be accessed.	Upon receipt of statement
Budget	Budget plans are available (for those who qualify) to allow patients to make routine payments on an account balance.	On the set weekly or monthly date
Per Service	Patients without effective insurance coverage are provided with and are required to pay all charges prior to the rendering of services.	Prior to service

Patient Responsibilities	
Insurance Participation	To avoid creating a large account balance and experiencing other complications, please contact the Billing Department prior to an insurance change to ensure the insurance is accepted. Only payments made from participating insurances are accepted as payment in full after co-pays, co-insurances and deductibles.
Insurance Benefits	The insurance company sets all policy benefits. Patients are responsible for covering any amounts not covered by their insurance; therefore, patients should contact their insurance company to verify their benefits prior to receiving a service.
Information Updates	All changes in demographic and insurance information must be reported no later than the subsequent appointment.
Authorization/Referral	All required insurance prior-authorizations and referrals must be checked and obtained by the patient prior to services being rendered.
Account Balances	Any account balance must be paid upon receipt of a statement. All questions in regards to a balance or a statement should be directed immediately to the Billing Department. Interest-free budget plans can be established for those who are eligible. Accounts in a delinquent status will be transferred to a collections firm.
Fees	For each bounced check, a $28 fee is assessed to an account to cover bank charges.

Contact Information		
Main Phone (315) 472-7504	Billing Department (315) 234-2812	Budget Plans/Collections (315) 472-7504 ext. 1079

Patient Agreement	
I acknowledge that I understand and agree to comply with the above Hematology-Oncology Assoc. of CNY policies. I have also been provided the opportunity to ask questions pertaining to the content of this agreement and have been provided contact information for any future questions.	
Patient Signature	Date
Spouse/Parent**(s)**Signature	Date
Patient Representative Signature**	Date

**Represented by: □ Conservator □Power of Attorney/Health Care Proxy □Legal Guardian □Parent (if patient is a minor)