# Yearly Information Updates

Full Name: ______________________________________ Maiden Name: ________________

DOB: ________________ Soc. Security #:_____________ Gender (*circle*): Male/Female

Address: ______________________________________________________________________

City: ________________ State: ________________ Zip: ________________

Home PH: ________________ Work PH: ________________ Cell PH: __________________

Email: ___________________________________ Access to our Patient Portal? Yes/No

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Ethnicity (*circle*): Hispanic or Non-Hispanic Race: ________ Primary Language: _______________

Marital Status (*circle*): Single Married Partner Divorced Separated Widowed

Employment (*circle*): Employed or Retired Employer: ___________________________________

Preferred Pharmacy Name: _________________________ Location: _________________________

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Primary Care Physician: __________________________________________

Referring Physician: __________________________________________

Additional Provider(s): __________________________________________

*The providers listed will receive communications from our office*

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| | | | | |
|---|---|---|---|---|
| **Do you have a Living Will?** | (*circle*) | Yes | No | Unknown |
| **Durable Power of Attorney?** | (*circle*) | Yes | No | Unknown |
| **Do Not Resuscitate Order?** | (*circle*) | Yes | No | Unknown |

## AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL HEALTH INFORMATION

This authorization gives Satish A. Shah, M.D., PLLC permission to use and/or disclose health information about you. I authorize the release of health information as indicated above to the following representatives/family:

| | | |
|---|---|---|
| ______________________________ | ____________________ | __________________________ |
| Name (***Primary Contact)*** | Relationship | Phone Number |
| ______________________________ | ____________________ | __________________________ |
| Name (***Primary Contact)*** | Relationship | Phone Number |
| ______________________________ | ____________________ | __________________________ |
| Name (***Primary Contact)*** | Relationship | Phone Number |

PENNSYLVANIA CANCER SPECIALISTS
Research Institute

# Please read this entire document before signing

My signature authorizes the disclosure of all protected information for the purpose of review and evaluation in regards to my treatment with Satish A. Shah, M.D., PLLC I expressly request that the designated record custodian of all covered entities under HIPAA identified on this form full and complete protected medical information including as specified in the following: medical records, meaning every page in my record including but not limited to office notes, face sheets, history & physical, consultation notes, social worker records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, billing records statements, pharmacy/prescription records, disability forms, questionnaires/histories, correspondence, photographs, videotapes, telephone message, and records received by other medical providers.

My signature or my appointed representative's signature certifies that I understand I have the right to revoke this authorization--in writing--at any time.

My signature or my appointed representative's signature certifies that I understand the information released in response to this authorization may be re-disclosed to other parties and that my insurance information is correct to the full extent of my knowledge.

My signature or my appointed representative's signature certifies Satish A. Shah, M.D., PLLC. to apply to my insurance for benefits on my behalf for covered services. I authorize the release to my insurers of medical and other coverage information necessary to process my claims. I request that my insurers pay directly to Satish A. Shah, M.D., PLLC any benefits to which I may be entitled for their services.

My signature or my appointed representative's signature certifies **I understand that I am responsible for all charges whether or not paid by insurance; this includes Co-Payments, deductibles, Co-Insurance (if applicable), charges not covered by insurance, etc.** ***NOTE: if my insurance fails to pay for my services with Satish A. Shah M.D., PLLC I understand that I may be billed and expected to pay for services rendered.***

My signature or my appointed representative's signature certifies my consent to the use and disclosure of my health information for treatment, payment, and health care operations purposes as mandated under HIPAA and described as above.

______________________________________ ____________________

Print Patient or Personal Representative Name Patient's Date of Birth

______________________________________ ____________________

Sign Patient or Personal Representative Name Date

***This Authorization shall expire 12 months from the date executed***

PENNSYLVANIA
CANCER SPECIALISTS
Research Institute

# Late Arrival Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must remain on scheduled time with each patient visit. In the event a patient is running behind to a scheduled visit we request you contact our office staff prior to ensure the appointment is able to be kept. Any patient who arrives 10 minutes or longer after scheduled visit time will be asked to reschedule unless the provider can accommodate.

# Cancellation Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must understand the value in each appointment time we offer to our patients. In the event one is unable to keep a scheduled appointment we ask you to notify our staff within 24 hours so we can provide that empty appointment slot to another patient in need. In the event a cancellation is made within 23 hours of scheduled appointment time the patient will be charged a $20.00 cancellation fee.

# No Show Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must understand the value in each appointment slot we offer to our patients. In the event one is unable to keep a scheduled appointment we ask you to notify our staff within 24 hours so we can provide that empty appointment slot to another patient in need. In the event a patient no-show any visit without contacting our office a $35.00 no-show fee will be charged. If a patient no-shows three times they will be dismissed as a patient of Gettysburg and Hanover Cancer Center

______________________________________ ____________________

Print Patient or Personal Representative Name Patient’s Date of Birth

______________________________________ ____________________

Sign Patient or Personal Representative Name Date

***This Authorization shall expire 12 months from the date executed***