

PATIENT PERSONAL DATA

Print full name: _____

Date of Birth: _____

Social Security Number: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

The insurance and guarantor information I have provided is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Virginia Breast Center or insurance company to release any information required to process my claims.

Patient/Guardian signature: *X*

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Virginia Breast Center's notice of privacy practices.

Patient/Guardian signature: *X*

Date:

COMMUNICATION AUTHORIZATION

I wish to be contacted in the following manner (check all that apply):

Telephone Communication

Written Communication

Home telephone #: _____
Leave message with detailed information
Leave message with call back number

Mail to home address
Fax to this number: _____
Email address: _____

Cell phone #: _____
Leave message with detailed information
Leave message with call back number

Work Telephone # _____
Leave message with detailed information
Leave message with call back number

I hereby give permission for Drs. James V. Pellicane and Polly L. Stephens to disclose information regarding my treatment to:

Spouse: _____
Print full name

Son/Daughter: _____
Print full name(s)

Other Relative: _____
Print full name and relationship

Other Healthcare Providers taking part in your medical care: _____
*** be specific**

In signing this release I authorize my medical records to be faxed or mailed upon my request.

Patient/Guardian signature: *X*

Date: