



NORTHPOINT CANCER CENTER

12606 Greenville Ave • Suite 160 • Dallas • TX • 75243 • Ph: 469.364.7880 • Fax: 469.364.7895

## BILLING INFORMATION AND ASSIGNMENT OF BENEFITS

Facility:

\_\_\_\_\_ Northpoint Radiation Center

\_\_\_\_\_ Pro Physicians Clinic PA

Physician:

\_\_\_\_\_ Timothy D. Nichols, M.D. PA, Board Certified Radiation Oncology

\_\_\_\_\_ Wilhelm J. Lubbe, M.D. Ph.D., Board Certified Radiation Oncology

The staff at this facility appreciates the opportunity to participate in your care and we will do our best to see that you receive the best possible care.

When your radiation treatments have been completed, you will receive TWO statements. You will receive one bill from the facility indicated above and a separate bill from your physician's billing office, also indicated above. The physician's professional fee for planning and directing your treatment is billed separately from the facility charges. If you have any questions regarding how the billing process works, please contact our insurance and billing coordinator.

After you register, we will provide the physicians with the information they will need to file your insurance claim(s) for you, including this form. Please assist us in the billing process by signing this authorization to be submitted with your insurance claims.

I authorize the release of any medical information necessary to process this claim and request payment of insurance proceeds, including major medical benefits to the doctor and/or facility indicated above. This will also serve as authorization for the doctor's office to obtain insurance information regarding any claims submitted on my behalf. In consideration of services rendered and to be rendered, I assign and transfer any benefits payable for my treatment to this facility. I request that payment of authorized benefits be made on my behalf. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. A copy of this signature is as valid as the original.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Witness

\_\_\_\_\_  
Date



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AUTHORIZATION FOR CARE

I grant permission for the employees of this facility to render routine care during my treatment period in order to carry out all orders of my attending physician. I understand that such care might include tests, examinations, and medical treatment. A practitioner is a member of the medical staff but is not an employee of the facility.

An Advanced Directive, such as a living will or medical power of attorney, is not required. However, you may request to receive material about your rights to accept or refuse medical treatment in the event of incapacitation. If given an advance directive, we comply with the written instruction you provide. Please request this form from the front desk personnel of this facility so it may be documented in your medical record.

I understand that neither this facility nor its staff members are responsible for any personal items or valuables brought to this facility.

INDEPENDENT PHYSICIAN NOTICE: I understand that the physicians participating in my care at this facility are not employees or agents of this facility. They are independent physicians who are engaged in the private practice of medicine who have been granted privileges to use this facility for the care of their patients. The services provided by these physicians are separate from the services provided by this facility and I understand that I will receive a separate bill for each.

ACKNOWLEDGEMENT OF PRIVACY POLICY NOTICE: I have been provided a copy of the notice of privacy practices and have been given the opportunity to read it and/or have it read to me. I acknowledge my right to ask questions and receive a copy at any time.

\_\_\_\_ **Patient/Patient representative Initial**

I, the undersigned patient or patient representative, have read the above information or had it read to me, and I understand the information.

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patients Name

\_\_\_\_\_  
Facility Witness

\_\_\_\_\_  
Date



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: \_\_\_\_\_
Date of treatment: \_\_\_\_\_

Date of birth: \_\_\_\_\_
Social security number: \_\_\_\_\_

Information may be released to:

Northpoint Cancer Center
12606 Greenville, Ave. Ste 160
Dallas, Tx 75243
Fax: (469) 364-7895

OR

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Please release the following information:

- \_\_\_ Consultation Reports
\_\_\_ History & Physical
\_\_\_ Discharge Summary
\_\_\_ Itemized Bill
\_\_\_ Other: \_\_\_\_\_

- \_\_\_ Progress Notes
\_\_\_ X ray Reports
\_\_\_ X ray Films/Images
\_\_\_ Pathology

The information above is to be released for the following purpose:

- \_\_\_ Treatment \_\_\_ Attorney \_\_\_ Social Security
\_\_\_ Consultation \_\_\_ Patient Request \_\_\_ Billing or Claims
\_\_\_ Other: \_\_\_\_\_

Drug, Alcohol Abuse, Psychiatric, and/or HIV/AIDS Records Release: I understand that if my medical or billing record contains information in reference to any drug, alcohol abuse, psychiatric, and/or HIV/AIDS testing and/or treatment, I agree to its release.

\_\_\_ Yes \_\_\_ No \_\_\_ Initial

Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I reserve the right to revoke this authorization by submitting a written notice to this facility at the above address.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative: I understand that signing this authorization form is voluntary and I may refuse to sign this form. My treatment is not conditioned on if I sign this authorization.

Signature of Patient or Legal Representative

Date

Authority to sign if not patient (documentation of authority required) \_\_\_\_\_

Identity or Requestor verified via: \_\_\_ Photo ID \_\_\_ Matching signature verified by: \_\_\_\_\_



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CONSENT TO DISCUSS HEALTH CARE INFORMATION

I understand that information such as my presence in the facility, as described in the Northpoint Cancer Center Notice of Privacy Practices, may be released to all who ask for me by name, unless I object by specifically requesting otherwise below.

STANDARD DICLSOSURE: I authorize this facility and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I designate the following persons to have access to information about me that is created by or on behalf of Northpoint Cancer Center, and this information can include protected health information. I understand that I have the right to revoke these designations and may do so by filling out a new form and that this authorization will not expire unless I do so. This authorization does not allow the following persons to receive a paper or electronic copy of my medical records without having my completed Authorization to Release Medical Record Information form.

Name Relationship
Name Relationship
Name Relationship

NO INFORMATION: I do not authorize the release of any information concerning my treatment. I understand that this includes all protected health information. I choose to be a "No Information" patient.

Signature of Patient or \*Legally Authorized Representative Printed Name

Relationship (if not patient) Date

Facility Witness Date

\*For purposes of this form only. A Legally Authorized Representative: is: 1) a legal guardian 2) an agent authorized in a medical power of attorney 3) an attorney appointed by the court 4) an attorney retained by the patient or the patient's legally authorized representative or 5) a parent or legal guardian of a minor.



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FINANCIAL AGREEMENT

Financial Responsibility: I understand that if the facility or my attending physician is not paid in full by proceeds of any benefits, this agreement does not release my obligation to the facility or attending physician for payment of all services rendered. In the event no benefits are paid by the responsible parties within 45 days of billing, then I agree to pay for all charges incurred. In the event benefits are paid by the responsible parties, then I agree to pay the facility or attending physician all charges in excess of benefits paid and portions assigned to patient responsibility. I understand and agree that in the event I am unable to pay in full at the time services are rendered, the business office can provide an installment plan to assist in payment. I understand that I must contact the business office to discuss this option and plans that are available. If no attempt is made to make payment arrangements after three monthly statements, a collection letter may be sent. I further understand that should this account be referred to an attorney or collection agency for collection or suit, I agree to pay all reasonable attorney fees, costs, and collection expenses.

Ostensible Agent Clause: During your treatment at this facility, the treating physician may order additional tests or services that require a professional component charge. This is a separate expense charged by the physician for planning and providing services in addition to the charges billed by the facility. We cannot guarantee that all physicians involved in your treatment will be participating members of your health insurance plan.

Payment Policy: We feel it is important for you to understand the billing procedures of the facility and your responsibility as a patient regarding your account. Insurance information must be provided to the facility prior to your initial consultation so insurance may be verified before treatment begins. The final bill for services is usually available within several days of completion of service. At that time, insurance claims will be sent to your insurance company. Please contact the business office for an itemized copy of your bill. We will allow approximately 45 days for your insurance to process the claim(s). Texas law mandates that insurance is to pay within 30 days of receiving a claim. Remember, the facility will bill your insurance but in the event that insurance does not pay in a timely manner, the responsibility of this account may fall back to you. Please respond to any request from your insurance company for additional information promptly to avoid any payment delays. Payment for deductibles and coinsurance is required at or before the date of service. Checks returned for insufficient funds will result in a \$25.00 fee added to your patient balance. Please contact the business office with any inquiries or concerns regarding this financial agreement or billing procedures.

\_\_\_\_\_  
Signature of Patient/Representative      Relationship to Patient      Date

\_\_\_\_\_  
Print Name      Facility Witness      Date



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MEDICARE SECONDARY PAYER QUESTIONNAIRE

\*Please only complete the following questionnaire if you have Medicare

Are you receiving Black Lung (BL) Benefits?

\_\_\_ Yes \_\_\_ No If yes, date benefits began: \_\_\_\_\_

Are the services to be paid by a government research program?

\_\_\_ Yes \_\_\_ No

Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

\_\_\_ Yes \_\_\_ No

Is your illness/injury due to a work-related accident/condition?

\_\_\_ Yes \_\_\_ No If yes, date of injury/illness: \_\_\_\_\_

Is your illness/injury due to a non-work-related accident?

\_\_\_ Yes \_\_\_ No If yes, date of accident: \_\_\_\_\_

Are you entitled to Medicare based on:

\_\_\_ Age \_\_\_ Disability \_\_\_ End-Stage Renal Disease

Are you currently employed?

\_\_\_ Yes \_\_\_ No If applicable, date of retirement: \_\_\_\_\_

Do you have a spouse who is currently employed?

\_\_\_ Yes \_\_\_ No If applicable, date of retirement: \_\_\_\_\_

Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

		Circle one:	
___ Yes, both: Do(es) the employer(s) employ 20 or more employees?		Self	Spouse Both
___ Yes, self: Does the employer employ 20 or more employees?		Y	N
___ Yes, spouse: Does the employer employ 20 or more employees?		Y	N
___ No			

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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## NOTICE OF PRIVACY PRACTICES

Please review the following carefully, we are required by law to maintain the privacy of your protected health information and to provide you with this notice. We are also required to abide by the privacy policies and practices that are outlined in this notice.

This notice tells you:

- How we use and disclose your Protected Health Information (PHI)
- Our legal duties in respect to Protected Health Information (PHI)
- Your rights concerning Protected Health Information (PHI)

This notice applies to:

- Northpoint Cancer Center's staff, contractors, students and trainees, and our physicians
- Volunteer groups

### Uses and Disclosures

**Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may need to be shared with doctors, hospitals, pharmacists, therapists, nurses, labs, imaging centers, and other healthcare professionals and entities involved in your health care. Northpoint Cancer Center may provide services through contracted business associates such as medical transcription services and record storage. We require these contracted business associates to protect your health information.

**Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Northpoint Cancer Center. For example, information on the services you receive may be used to support budgeting, financial reporting, and activities to evaluate and promote quality. This information may be shared with those who pay for your care or with other agencies that review this data.

**Law Enforcement:** Your health information may be disclosed to legal officials such as: law enforcement agencies, court officials, government agencies, and/or attorneys to facilitate law-enforcement investigations and to comply with government-mandated

reporting. For example, your information may be used to report or if we believe, in good faith, release of such information is necessary to prevent abuse or neglect, domestic violence, or certain physical injuries. Your information may also be used in response to a court order, subpoena, warrant, or lawsuit request.

**Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Research:** Your health information may be disclosed to people preparing to conduct a research project so long as the medical information they review is not removed from the premises of this practice. We may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

**Appointment Reminders:** Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a specific confidential manner, please indicate your preference in the initial patient information paperwork you complete at your first appointment. If you decide you would like to change your preference, please let the front desk personnel know your change in preferred method of contact. You may be asked to re-fill out a form stating your new decision.

**Information about Treatments:** Your health information may be used by our staff to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**Other Uses and Disclosures:** Any other form of use or disclosure NOT listed above will require your written consent and authorization. Most disclosure for marketing purposes, or sale of protected health information, including subsidized treatment communications, will require your authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### Patient's Individual Rights

- You have the right to request restriction on the use and disclosure of your protected health information;
- You have the right to receive confidential communications concerning your medical condition and treatment;
- You have the right to inspect and copy your protected health information;
- You have the right to amend or submit corrections to you protected health information;
- You have the right to restrict certain disclosures of your health information to a health plan where you have paid out-of-pocket in full for a health service or item;



- You have the right to opt out of fundraising communications with each solicitation;
- The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the discrimination of a patient in group health plan coverage based on genetic information. No plan or insurer can use genetic information as part of their underwriting purposes.
- You have the right to, and will, be notified in the event of a breach of unsecured protected health information;
- You have the right to file a complaint with both this practice and/or the U.S. Department of Human and Health Services at the information given below;
- You have the right to receive an accounting of how and to whom your protected health information has been disclosed; &
- You have the right to receive a printed copy of this Privacy Practice Notice at any time

#### Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. There will also be a copy posted on this practices official website. The revised policies and practices will be applied to all protected health information we maintain.

#### Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

#### Complaints

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPPA Privacy Officer  
 Northpoint Cancer Center  
 12606 Greenville Ave, Ste. 160  
 Dallas, TX 75243

US Dept. of Health & Human Services  
 Office for Civil Rights Centralized Case  
 Management Operations 200  
 Independence Ave., S.W. Suite 515F,  
 HHH Building  
 Washington, D.C. 20201