FOR OFFICE USE ONLY	
Date of Consult: M/D/YYYY Date of Simulation: M/D/YYYY Account #:	Consult Location: Simulation Location: Treatment Area:

PATIENT INFORMATION

Name:
Address:
City: State: Zip:
Home Phone: ( ) -
Cell Phone: ( ) -

SSN: - -
Sex: ☐ Male ☐Female
Marital Status:
Date of Birth: M/D/YYYY
Race:

Responsible Party for this Account: ☐Self ☐ Spouse – Printed Name:

Signature: _____

Referring Doctor:
Phone: ( ) -
Address:
City: State: Zip:
UPIN#: Payer ID#:

Family Doctor:
Phone: ( ) -
Address:
City: State: Zip:
UPIN#: Payer ID#:

Do you have an advance directive?

Are you currently hospitalized or under skilled nursing care?
Hospital:
RM#: Admission Date: M/D/YYYY Discharge Date: M/D/YYYY

Are you currently enrolled in a Hospice program?
Name of program:
Date Started: M/D/YYYY Date Ended: M/D/YYYY

Person to contact other than someone living with you?

Name:
Address:
City: State: Zip:

Relation:
Phone: ( ) -

EMPLOYMENT INFORMATION

Last or Current Employer:
Address:
City: State: Zip: Phone: ( ) -
Occupation: Supervisor:

Employment Status: ☐Full-time ☐Part-time ☐Leave ☐Retired ☐Military

Cumberland Radiations Associates, LLC| Financial Information Form

Spouse or Next of Kin: Home Phone: ( ) -
Address: Work Phone: ( ) -
City: State: Zip:
Relationship: SSN: - - DOB: M/D/YYYY
Last or Current Employer: Employer Phone: ( ) -
Address:
City: State: Zip:

INSURANCE INFORMATION

Primary Coverage:
Carrier Name: Policy #:
Address: Group:
City: State: Zip:
Effective Date: M/D/YYYY Phone: ( ) -
Policy Holder: Relationship:

Secondary Coverage

Carrier Name: Policy #:
Address: Group:
City: State: City:
Effective Date: M/D/YYYY Phone: ( ) -
Policy Holder: Relationship:

Do you have a cancer policy? ☐ Yes ☐ No

Carrier Name: Policy #:
Address: Group:
City: State: City:
Effective Date: M/D/YYYY Phone: ( ) -
Policy Holder: Relationship:

I certify by signature that this information is true and correct.

Signed:_____ Date: M/D/YYYY

Cumberland Radiation Associates, LLC | William B. Bradford, M.D., Director

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

(A Copy shall be Valid as the Original)

Please read the following information as it applies to you. During the course of radiation therapy treatments, you will receive a statement for Cumberland Radiation Associates, LLC for the services performed by Dr. William Bradford and his staff of physicists, dosimetrists, and therapists. We will file all insurance claims in our office and the insurance companies will send payments directly to us for our services provided to you. We will also file any secondary insurance if you have other coverage.

Some services may not be covered by your insurance for which you will be responsible, also services are only covered as long as you are eligible according to you insurance plan.

We will accept the Medicare allowed amount for services, however, Medicare pays 80% of eligible charges, and the patient is responsible for the remaining 20%, unless you have a secondary insurance, which we will be glad to file for you. All other insurances pay according to the plan you have during your eligible dates, which may leave a balance for which you may be responsible. If you have any question regarding your plan, please call your insurance company. We want to help you understand our billing procedures and will be happy to assist you in any way we can. If you have any questions regarding your account with us, please call our billing office at 1-800-451-4959.

It is extremely important that you keep us informed of any changes in your insurance coverage as soon as possible.

MEDICARE

I authorize Cumberland Radiation Associates, LLC to release any information needed to the Social Security Administration or its intermediaries or carriers for the purpose of filing claims. I request that my insurance payments be made directly to Cumberland Radiation Associates, LLC for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

MEDICAID

I authorize Cumberland Radiation Associates, LLC to release any information needed to the Medicaid intermediary or carrier for the purpose of filing claims. I request that payments of benefits be made directly to Cumberland Radiation Associates, LLC. I acknowledge that I am financially responsible for any unpaid balance.

INSURANCE CARRIER

I authorize Cumberland Radiation Associates, LLC to release any information needed to my insurance carrier for the purpose of filing claims. I request that payments of benefits be made directly to Cumberland Radiation Associates, LLC. I acknowledge that I am financially responsible for any unpaid balance.

Signature of patient or authorized Representative

Relation to Patient

Physician's Representative

Date Signed M/D/YYYY

Cumberland Radiation Associates, LLC does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs.

RELEASE of MEDICAL INFORMATION

Cumberland Radiation Associates, LLC

William B. Bradford, MD
2114 N. Jackson Street
Tullahoma, TN 37388

931-454-9002
931-454-9690 (FAX)

Please release the medical records in your possession for the following patient:

Name:

Address:

City: State:

Date of Birth: M/D/YYYY SS#: - -

)ate medical records are needed: M/D/YYYY

X

Signature

William B. Bradford, MD
2114 N. Jackson Street
Tullahoma, TN 37388

931-454-9002
931-454-9690 (FAX)

Cumberland Radiation Associates, LLC

DISCLOSURE AND CONSENT FOR RADIATION THERAPY

Name of Patient:	Acct/Chart #:

As a patient you have the right to be informed about your condition and recommended radiation therapy procedure to be used to treat your condition. This disclosure is not meant to alarm you: however, there are certain risks that are associated with radiation therapy. This explanation is intended to inform you of those risks so that you may give or withhold your consent to the recommended procedure on an informed basis. Please carefully review the following and if you choose to proceed with this treatment, sign this consent in the space below.

I hereby voluntarily request and authorize Dr. Bradford as my physician, and such associates, technicians, and health care providers as they may deem necessary to treat my condition.

I understand that my condition may be treated with external beam radiation therapy alone, with internal radiation implants alone, or with both, or in planned combination with surgery and/or chemotherapy.

I understand that radiation therapy procedures may be planned for me, and I consent to and authorize these procedures.

I further authorize the taking of photographs or the placing of tattoo or skin marks necessary for treatment.

I authorize any holder of medical or other information about me to release records to Dr. Bradford and any such associates, technicians, and the health care providers.

ALL FEMALES MUST COMPLETE: I understand that radiation can be harmful to the unborn child:

- ☐ I am,
- ☐ I could be,
- ☐ I am not pregnant.

I understand there may be side effects or complications from radiation therapy, either during or shortly after the course of treatment (“early reactions”) or sometime later (“late reactions”). Any of the side effects or complications may be temporary or permanent.

These reactions may be worsened by chemotherapy or surgery before, during, or after radiation therapy or by previous radiation therapy to the same area.

Signature of Patient or Responsible Party	Date
Signature of Physician	Witness

William B. Bradford, MD
2114 N. Jackson Street
Tullahoma, TN 37388

Cumberland Radiation Associates, LLC

931-454-9002
931-454-9690 (FAX)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

Uses and Disclosures: We will use and disclose elements of your Protected Health Information (PHI) in the following ways:

Without your signed authorization

- **Treatment:** We will disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to your referring physician or other physicians involved in your care and treatment to ensure that the physician has the necessary information to diagnose or treat you.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for testing from your insurance company may require that your relevant protected health information be disclosed to the health plan to obtain the approval for diagnostic testing or therapeutic radiation oncology.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment reviews, employee review activities, training of clinical and clerical staff, licensing and accreditation boards, conducting or arranging for other business activities. In addition, we may use sign-in sheets at the registration desk where you will be asked to sign your name. We may call you by name in the waiting room when the physician or technician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

- When release is required by law, including in judicial settings, health oversight regulatory agencies, public health issues as required by law, Communicable Diseases, Abuse, Neglect, FDA, medical examiners, funeral directors, organ and tissue donation organizations, legal proceedings, criminal activity, military activity, national security, Worker's Compensation, No-Fault. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the federal privacy regulation, and law enforcement.

- In emergency situations or to avert serious health/safety situations.

- In marketing efforts for ourselves.

- To the sponsor of your health plan

- Other permitted and required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

Your Rights: You have the following rights concerning you PHI:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny you request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: To register a complaint with us, contact our Privacy/Compliance Officer via a toll free number 1-877-91-Sonix. You may complain to us or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. The contact information is Office of Civil rights, U.S. Department of Health and Human Services, 601 East 12th Street Room 248, Kansas City, Missouri 64106 or call (818) 426-7278, Fax (816) 426-3686, TDD (816) 426-7065.

Our duties: We are required by law to maintain the privacy of you PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: For more information about our privacy practices, please contact: Jacqueline Selva, Corporate Compliance Officer, 1-877-91-Sonix.

Effective date: This notice was published and becomes effective on/or before April 14, 2003.

I acknowledge receipt of this notice:

Sign:_____ Date: M/D/YYYY

Print name of patient: Describe your authority:

William B. Bradford, MD
2114 N. Jackson Street
Tullahoma, TN 37388

931-454-9002
931-454-9690 (FAX)

Cumberland Radiation Associates, LLC

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Your health information is protected by the "Health Insurance Portability and Accountability Act" (HIPAA) and as a result, we cannot discuss any personal information with family or friends unless you give up permission.

Please list the names of persons we are allowed to speak with and what relation they are to you. Please let them know, they must be able to verify your name, social security number, and birthday before any information may be released.

Name	Relation	Phone #
1.		( ) -
2.		( ) -
3.		( ) -
4.		( ) -
5.		( ) -
6.		( ) -

If you have any questions, please see the "Notice of Privacy Practices" for or ask the office staff. Thank you.

Patient's Name:

Patient's Signature_____

Date: M/D/YYYY

William B. Bradford, MD
2114 N. Jackson Street
Tullahoma, TN 37388

Cumberland Radiation Associates, LLC

931-454-9002
931-454-9690 (FAX)

Medical Log

Patient Name:

Allergies:

Are you diabetic? ☐ **Yes** ☐ **No**

Pharmacy Name/Location:

Name of Drug	Dose	How often do you take it	Who prescribed it for you