

# The Blood and Cancer Clinic P.A.

1565 Purdue Drive, Suite 301  
FAYETTEVILLE, NC 28303  
Telephone # (910) 483-8586  
Fax # (910) 483-9212

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*Medical Oncology, Hematology and Internal Medicine*

## INSURANCE INFORMATION SHEET

Date: \_\_\_\_\_

Please complete all required information below and return to our office at least five (5) days prior to your first visit. Thank you for your cooperation.

Patient Name: \_\_\_\_\_  
Last First Middle

Name of Person Insured: \_\_\_\_\_  
Last First Middle

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_  
Street City State/ Zip code

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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**IF THERE IS ANOTHER INSURANCE COMPANY PROVIDING BENEFITS FOR THE PATIENT, PLEASE COMPLETE THE FOLLOWING SECTION:**

Name of Person Insured: \_\_\_\_\_  
Last First Middle

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_  
Street City State/ zip code

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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Medicare Information: \_\_\_\_\_  
Name of Recipient Number

Dates of Eligibility: \_\_\_\_\_

Medicaid Information: \_\_\_\_\_

Dates of Eligibility: \_\_\_\_\_

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**I understand and agree that regardless of my insurance status I am directly responsible for the balance on my account for any professional services rendered. I understand that there is a 1.5% monthly interest charge on the balance if not paid in full within 30 days of receiving a bill from The Blood and Cancer Clinic, P.A. Any refunds due to patients will be sent out at the next billing cycle and after all insurance has paid on the account.**

**I will be paying my first visit by: CASH: \_\_\_\_\_ CHECK: \_\_\_\_\_ CREDIT CARD: \_\_\_\_\_**

**Copy of Drivers License # \_\_\_\_\_**

**Special notes of comments by patient:**

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**Your picture will be taken on your first visit and will be a permanent part of your confidential medical records that will belong to The Blood and Cancer Clinic, P.A.**

**I have read and completed all information on this form. I certify that this information is true and correct to the best of my knowledge.**

**PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_**

**SIGNATURE OF SPOUSE/GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_\_**