

The Blood and Cancer Clinic P.A.

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Shirish D. Devasthali, M.D.
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Diplomates of American Board of
Medical Oncology, Hematology and Internal Medicine

Date: _____

Dear: _____

OFFICE HOURS 8:30AM – 5:00PM

Thank you for allowing The Blood and Cancer Clinic, P.A., to provide medical services to you and your family. This letter will serve as an introduction to our office policies and procedures and hopefully assist you in completing the new patient registration forms. By completing these forms as soon as you come into the office, your waiting time maybe reduced. Please be certain that all necessary information is completed. Patients must make sure that all medical records (physician notes, labs, pathology and x-ray reports, etc.) are available for review on or before your first visit with The Blood and Cancer Clinic, P.A. Unavailability of these records may lead to unnecessary delays.

_____ YES _____ NO, I have/have not filled out the office policy within the last year.

IF YOU NEED TO CHANGE OR CANCEL ANY APPOINTMENTS FOR ANY REASON, WE NEED A 24 HOUR NOTICE OR A \$25.00 CHARGE WILL BE BILLED TO YOUR ACCOUNT. I CONSENT FOR THE BLOOD AND CANCER CLINIC TO NOTIFY ME OF MY APPOINTMENT BY TELEPHONE AND CAN LEAVE A MESSAGE IF I AM NOT AVAILABLE AND/OR VIA EMAIL IF NECESSARY.

Also, in signing this office policy I acknowledge that I have received and/or reviewed the Patient Bill of Rights Privacy Notice.

Thank you for your help as we strive to care for you in the most professional and effective manner.

PATIENT SIGNATURE: _____ DATE _____

WITNESS SIGNATURE: _____ DATE _____