

# Virginia Cancer Institute Patient Demographic Profile

## PATIENT INFORMATION

Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Race:  African American  American Indian  Caucasian  
 Hispanic  Asian  Other

Phone: \_\_\_\_\_  Home  Work  Cell

Marital Status:  Married  Single  Divorced

Phone: \_\_\_\_\_  Home  Work  Cell

Referring Physician: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Living Will  Yes  No DNR  Yes  No

Durable Medical Power of Attorney  Yes  No

## RESPONSIBLE PARTY

Same as Patient

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City, State: \_\_\_\_\_

## EMPLOYMENT

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PRIMARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

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

## SECONDARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

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

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

I authorize Virginia Cancer Institute to provide medical treatment to me. I understand that I am financially responsible for charges incurred by me and that in the event that my account is turned over to an attorney for collection, I shall be responsible for attorney fees and court costs. I further authorize Virginia Cancer Institute to release medical information necessary to process my claims. In the event that any employee is exposed to my blood and/or body fluids, I consent to laboratory testing for Hepatitis B, Hepatitis C and AIDS antibody and that the results of those tests be shared with the exposed party. A photocopy of this information shall be considered as valid as the original.

Signature of Patient/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

CONSENT TO RELEASE OF  
CONFIDENTIAL HEALTH INFORMATION

*We frequently have phone calls from family members inquiring about the health status or treatment of a patient. To protect confidentiality, we ask that you notify us of any family members or others to whom you may wish to have your medical information disclosed. If a family member is not listed below, they will NOT be given information regarding your medical care and treatment.*

PATIENT NAME: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_

RELEASE INFORMATION TO:

NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

As the person signing this consent, I understand that I am giving my permission to Virginia Cancer Institute, Inc. to release my confidential medical information to the individual(s) named above. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to Virginia Cancer Institute, Inc. A copy of this consent shall be included with my original records. 32.1-127.1:03

I authorize Virginia Cancer Institute, Inc. to disclose any and all information regarding my medical treatment to the individuals named above unless such release is otherwise limited as follows:

\_\_\_\_\_  
\_\_\_\_\_  
Virginia Cancer Institute, Inc. is \_\_\_\_\_ is not \_\_\_\_\_ authorized to leave messages on my home answering machine regarding \_\_\_\_\_ appointment notification \_\_\_\_\_ please call office.

This consent shall not expire unless I notify Virginia Cancer Institute, Inc. that this release is revoked.

Signed: \_\_\_\_\_

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

## PATIENT RESPONSIBILITY FOR PAYMENT

You are responsible for any services rendered by the physicians or staff of Virginia Cancer Institute, Inc. Your health insurance will be billed for you to whenever possible when the information is supplied at the time of your service, however, the contract with your carrier is between you and the company. We cannot intervene to change the type or amount of coverage that you have. You are responsible for being aware of any deductibles, copayments, and non-covered services. You will be expected to pay these amounts at the time of service, unless other arrangements have been made in advance. Some insurance companies require a referral or pre-authorization before you can be treated by a specialist. It is your responsibility to bring this information with you at the time of your visit. We reserve the right not to see you if the referral is not here at the time of your visit.

YOU ARE RESPONSIBLE FOR ANY SERVICES RENDERED BY THIS PRACTICE THAT ARE NOT PAID BY YOUR INSURANCE CARRIER. YOU ARE RESPONSIBLE FOR ANY COLLECTION AGENCY COSTS, COURT COSTS, OR ATTORNEY'S FEES INCURRED BY THE PRACTICE IN COLLECTING ANY OUTSTANDING BALANCE FOR SERVICES RENDERED TO YOU.

### AUTHORIZATION STATEMENTS:

#### 1) Medicare Patients Lifetime Agreement

I authorize any holder of medical or other information about me to release such information necessary for the processing of Medicare claims to Social Security Administration and the Health Care Financing Administration or its intermediaries, carriers, billing agents or successors. I further permit a copy of this authorization to be used in place of the original and I request payment under Medicare to be made to either me or to the physicians, providers, or suppliers identified for service and/or supplies furnished by those physicians, providers, or suppliers.

2) I authorize Virginia Cancer Institute, Inc. to release or obtain any information necessary in the course of my treatment for billing or medical requirements.

3) I authorize my health insurance carrier(s) to pay Virginia Cancer Institute, Inc. directly for the medical, laboratory, surgical procedures, and/or other services rendered to me under the benefits/terms of my policy.

4) I further permit a copy of this authorization to be used in place of the original and request payment under Medicare to be made to Virginia Cancer Institute, Inc. for services and/or supplies furnished during my treatment.

I understand that I am directly responsible for all services rendered.

I have read and understand all of the above and agree with the terms of this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Virginia Cancer Institute Notice of Privacy Practices

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 carefully.

If you have any questions about this Notice, please contact the Privacy Officer.  
804-673-0134

Effective Date: April 14, 2003

Revised: November 3, 2015

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office,
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: <http://vacancer.com>

### Uses and Disclosures of Protected Health Information

**We may use or disclose (share) your PHI to provide health care treatment for you.**

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

**We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.**

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

**We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.**

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

**We may use and disclose your PHI in other situations without your permission:**

- **If required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Legal proceedings:** To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- **Medical research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Other uses and disclosures of your health information.**

**Business Associates:** Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

**Health Information Exchange:** We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

**We may use or disclose your PHI in the following situations UNLESS you object.**

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

**The following uses and disclosures of PHI require your written authorization:**

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

**Your Privacy Rights**

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You may request an Authorization for Disclosure of Health Care Information form verbally or by written request. Once you have completed and signed this document, you must return the original to the Privacy Officer for processing.

**You have the right to see and obtain a copy of your protected health information.**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

**You have the right to request a restriction of your protected health information.**

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

**There is one exception:** we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

**You have the right to request for us to communicate in different ways or in different locations.**

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

**You may have the right to request an amendment of your health information.**

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

**You have the right to a list of people or organizations who have received your health information from us.**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

**Additional Privacy Rights**

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

**Complaints**

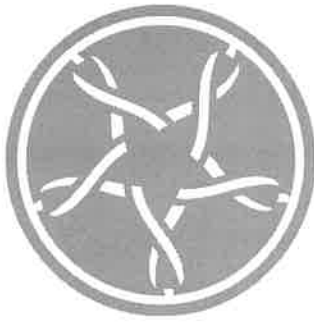
If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

**Privacy Officer 804-673-0134**

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003.



# Virginia Cancer INSTITUTE

PERSONAL ATTENTION & LEADING-EDGE CARE SINCE 1981

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## Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_  
Signature Date

For Office Use Only

**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Prepared By \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Date: \_\_\_\_\_

Please fill out this form as completely as you can. It provides vital information to help your physician and staff care for you. All of your medical information is held in strictest confidence, and is only released to others in accordance with your wishes and federal privacy guidelines.

Preferred Pharmacy, including address and phone # \_\_\_\_\_

Please list all physicians involved in your care, including your primary care physician, the physician who referred you here, your surgeon, your radiation oncologist, and any other physician involved in your care

Physician that referred you to this practice:	
Primary Care Physician	Other
Surgeon	Other
Radiation Oncologist	Other

Drug Allergies	Type of Reaction

**Current Medications (Attach Additional Sheet if Needed)**

Name of Medication	Dosage	How Often	Year Started

Are you currently taking blood thinners? \_\_\_ Yes \_\_\_ No

If yes, how long? \_\_\_\_\_ Who manages your blood thinner prescription? \_\_\_\_\_

**Current Symptoms:**

- |   |   |  |  |   |  |  |
|---|---|--|--|---|--|--|
| <input type="checkbox"/> fatigue              | <input type="checkbox"/> fever              | <input type="checkbox"/> chills                | <input type="checkbox"/> night sweats              | <input type="checkbox"/> lethargy         | <input type="checkbox"/> loss of appetite    | <input type="checkbox"/> weight change                 |
| <input type="checkbox"/> ear pain             | <input type="checkbox"/> hearing loss       | <input type="checkbox"/> trouble seeing        | <input type="checkbox"/> sensitivity to light      | <input type="checkbox"/> excessive tears  | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> significant pain              |
| <input type="checkbox"/> mouth sores          | <input type="checkbox"/> mouth dryness      | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough                     | <input type="checkbox"/> sensory problems | <input type="checkbox"/> swelling            | <input type="checkbox"/> disorientation                |
| <input type="checkbox"/> palpitations         | <input type="checkbox"/> rash               | <input type="checkbox"/> dry skin              | <input type="checkbox"/> decreased range of motion | <input type="checkbox"/> nipple discharge | <input type="checkbox"/> bleeding            | <input type="checkbox"/> weakness                      |
| <input type="checkbox"/> breast pain          | <input type="checkbox"/> breast masses      | <input type="checkbox"/> new lumps             | <input type="checkbox"/> hot flashes               | <input type="checkbox"/> constipation     | <input type="checkbox"/> incontinence        | <input type="checkbox"/> problems with sexual function |
| <input type="checkbox"/> nausea               | <input type="checkbox"/> vomiting           | <input type="checkbox"/> heartburn             | <input type="checkbox"/> diarrhea                  | <input type="checkbox"/> blood in urine   | <input type="checkbox"/> seizures            | <input type="checkbox"/> poor balance                  |
| <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> frequent urinating | <input type="checkbox"/> insomnia              | <input type="checkbox"/> dizziness                 | <input type="checkbox"/> memory loss      |  |  |

**Medical History (Please check any conditions that apply to you)**

	<i>For MD / RN Use</i>
<input type="checkbox"/> Allergies / Hayfever	
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Angioplasty / Stent Placement	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Bleeding Tendency	
<input type="checkbox"/> Chronic Anxiety <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Congestive Heart Failure (CHF) <input type="checkbox"/> Depression	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Emphysema or Chronic Bronchitis <input type="checkbox"/> GERD <input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Heart Attack (MI) <input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Peripheral Vascular Disease (Arterial Obstruction)	
<input type="checkbox"/> Pneumonia <input type="checkbox"/> Reflux / Heartburn	
<input type="checkbox"/> Renal Insufficiency (Decreased Kidney Function)	
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Seizure	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Urinary Difficulty <input type="checkbox"/> Urinary Incontinence	
<input type="checkbox"/> Venous Thrombosis (Blood Clots) <input type="checkbox"/> Visual Loss	
<input type="checkbox"/> Cancer Type: _____ Age at Diagnosis: _____ Where were you treated? _____	
<input type="checkbox"/> Other Medical Problems (Please list) _____ _____ _____	



<b>Surgical History</b>	<b>M / D / Y</b>	<b>For MD / RN Use Only</b>
<input type="checkbox"/> Appendix Removed		
<input type="checkbox"/> Blood Transfusion		
<input type="checkbox"/> Breast Biopsy		
<input type="checkbox"/> Cataract Removal		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> Coronary Artery Bypass		
<input type="checkbox"/> Gall Bladder Removed		
<input type="checkbox"/> Hernia Repair		
<input type="checkbox"/> Hip Replacement		
<input type="checkbox"/> Knee Replacement		
<input type="checkbox"/> Mastectomy		
<input type="checkbox"/> Mastectomy, partial (lumpectomy)		
<input type="checkbox"/> Other Joint Surgery		
<input type="checkbox"/> Other Surgery		
<input type="checkbox"/> Pacemaker Placement		
<input type="checkbox"/> Prostate Surgery		
<input type="checkbox"/> Tonsils Removed		
<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> Uterus or Ovaries Removed		
<input type="checkbox"/> Vasectomy		

**GYN History (Women Only)**

# of pregnancies ____ # of live births ____	Menopausal Status <input type="checkbox"/> Pre- <input type="checkbox"/> Post- <input type="checkbox"/> Peri- <input type="checkbox"/> Unknown	Age at Menopause ____
Hormone Use                      # Years Used <input type="checkbox"/> Birth Control Pills                      _____ <input type="checkbox"/> Post-Menopausal                      _____ <input type="checkbox"/> Other                      _____	_____ Date of Last PAP Smear _____ Date of Last Mammogram	Other GYN History:

**Family History**

	Alive?	History of Cancer (Specify Type)	Age of Death	Age Diagnosed with Cancer	Anemia	Clotting Disorder	Bleeding Disorder
Mother	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother / Sister	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother / Sister	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother / Sister	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	Y / N				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





# Virginia Cancer INSTITUTE

PERSONAL ATTENTION & LEADING-EDGE CARE SINCE 1981

## Pre-screening Patient Assistance Application

This form is optional. Complete only if you wish to pursue Patient Assistance.

Cancer treatments are expensive and, unfortunately, not all insurance companies will pay all of the associated costs. However, there are patient assistance programs available that may help offset some of the expenses you may incur. If you would like for our Financial Counselor to see if you qualify for any of these programs please complete and provide the following information.

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Household Income: \_\_\_\_\_ Number of People in Household: \_\_\_\_\_

Some programs require proof of income. If approved, you may be asked to provide one or more of the following:

- Copy of your most recent federal tax return, if you file taxes or tax exempt form
- Copies of all current income documentation (W2, SSI, or last three pay stubs)

"Due to my financial situation, I certify that I am unable to meet my financial obligation to Virginia Cancer Institute. In addition, I acknowledge that the information I have provided on this form is accurate and complete. I hereby authorize Virginia Cancer Institute to verify any and all information disclosed and understand that this information will be used by Virginia Cancer Institute solely to determine my ability to pay for services provided by the Virginia Cancer Institute. I understand that the Virginia Cancer Institute reserves the right at any time, and without notice, to modify this application form; modify or discontinue any or all of the program and related eligibility criteria; or terminate assistance provided by the program at any time."

### Patient or Responsible Party Signature

### Date

**Reynolds Crossing**

6605 W. Broad St.  
Suite A  
Henrico, VA  
23230  
804-287-3000  
FAX 804-673-2731

**Johnston Willis**

1401 Johnston Willis Dr.  
Suite 100  
Richmond, VA  
23235  
804-330-7990  
FAX 804-330-2701

**Bell Creek Square**

7501 Right Flank Rd.  
Suite 600  
Mechanicsville, VA  
23116  
804-559-2489  
FAX 804-730-5847

**Harbourside**

6130 Harbourside Centre Loop  
Suite 101  
Midlothian, VA  
23112  
804-378-0394  
FAX 804-739-7649

**Business Office**

7202 Glen Forest Dr.  
Suite 200  
Henrico, VA  
23226  
804-673-0134  
FAX 804-673-1796

**Southside Regional**

210 Medical Park Blvd.  
Suite 200  
Petersburg, VA  
23805  
804-431-1100  
FAX 804-862-1094

**Puddledock**

4730 Puddledock Rd.  
Suite 100  
Prince George, VA  
23875  
804-452-3850  
FAX 804-541-7585