

SOUTHBAY ONCOLOGY HEMATOLOGY PARTNERS  
PATIENT INFORMATION      A# \_\_\_\_\_

**Martin D. Rubenstein, M.D.**  
**Steven M. Scates, M.D.**  
**May C. Chen, M.D.**

**Martha C. Man, M.D.**  
**Thomas T. Chen, M.D, Ph.D**

**PLEASE PRINT AND FILL OUT COMPLETELY:**

*DOCTOR YOU ARE HERE TO SEE* \_\_\_\_\_  
LAST NAME \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME TELEPHONE # \_\_\_\_\_ ALTERNATE # \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
WORK TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
SPOUSE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_ WORK PHONE # \_\_\_\_\_  
SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_  
PRIMARY INSURANCE COVERAGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
I.D.# \_\_\_\_\_ GROUP # \_\_\_\_\_  
SECONDARY INSURANCE COVERAGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_  
*PRE-AUTHORIZATION REQUIRED* \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_  
REFERRED BY \_\_\_\_\_  
*PRIMARY CARE PHYSICIAN* \_\_\_\_\_  
IN CASE OF EMERGENCY CONTACT \_\_\_\_\_  
PHONE \_\_\_\_\_ ADDRESS \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
MAIL ORDER PHARMACY NAME \_\_\_\_\_  
RETAIL PHARMACY NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

**RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize my physician and Southbay Oncology Hematology Partners (SBOHP) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physician regarding claims for medical services they provide me. I authorize Good Samaritan Hospital, O'Connor Hospital, and El Camino Hospital of Los Gatos to release information requested by SBOHP. I authorize SBOHP to release information to physicians referred by SBOHP. I authorize payments of assigned medical benefits to be paid directly to my physician and SBOHP. I am responsible for deductibles, coinsurance, and non covered items. I agree to pay any co-payments required by my insurance plan at the time of service.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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Dear Patient,

A number of our patients have questions regarding insurance reimbursement. This letter summarizes for you our billing policies, insurance billing procedures, and collections policy.

Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. This bill can be submitted by you, along with the appropriate forms, to your insurance carrier. Many of our patients prefer to have us bill the insurance carrier for them. We are pleased to provide this service for you. You must sign a release allowing us to bill your insurance carrier directly. Although we will try to help you as much as possible, responsibility for handling problems with insurance reimbursement rests with you. YOU are responsible for payment of your bill.

When you receive our monthly statement, payment is expected within 30 days unless special arrangements have been made. Charges are considered delinquent after 60 days. If no payment is received after 90 days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing problems directly with our billing office.

We strive to make our charges as cost effective as possible by delivering much of our care outside of the hospital. We recognize that the cost of chemotherapy is quite high. Our purchase price of these medications continues to increase. The passage of the Medicare Prescription Drug Improvement Act in 2003 dramatically reduced the reimbursement for drugs. All Medicare patients without secondary insurance must pay their co-insurance at the time of service or provide a credit card for all treatments provided at SBOHP.

Our goal is to assist you as much as possible with the financial aspects of your care. Our policy is designed to keep costs as low as possible for all of our patients. We hope that this information will be useful to you. A copy of this letter will be provided to you at your request.

Sincerely,  
Southbay Oncology Hematology Partners

My signature below indicates that I have read, understood, and agreed to the billing policies of Southbay Oncology Hematology Partners.

PATIENT SIGNATURE \_\_\_\_\_

**SOUTHBAY ONCOLOGY HEMATOLOGY PARTNERS**

**50 E. Hamilton Avenue, Suite 200**

**Campbell, CA 95008**

**408-376-2300 phone**

**408-376-2316 fax**

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**Wendy Sura, R.N., N.P**

**Our Commitment to Quality Medical Care**

Southbay Oncology Hematology Partners is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint – we value your feedback.** Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and **greatly** value your feedback.

**If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California.** We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800/633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov)).

*I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.*

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Patient/Patient Representative Signature

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Patient/Patient Representative Name – Please Print

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Date

## **Acknowledgement of Receipt of Notice of Privacy Practices**

Southbay Oncology Hematology Partners

50 E. Hamilton Ave., Suite 200

Campbell, CA 95008

Chief Privacy Officer 408-376-2300

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

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

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

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

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

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To Our Patients,

We are required by your health plan to collect co-payments at the time of service. This policy is established by your health plan and is explained in your benefits handbook. Additionally, your specific co-payment information is printed on your insurance card. If you have any questions or concerns about your co-payment requirements, please call your financial counselor directly.

Co-payments are required each time that you are seen by the physician. A co-payment is also required each time that you receive medication in the infusion center even if you are not seen by the physician. This co-payment is for the limited office visit charge which covers the medical management that the physician provides as he oversees your treatment. Again, this policy is established by your health plan.

We are sorry if collecting co-payments at the time of service creates any inconvenience for you. Thank you for your cooperation.

Agreed to and Understood by:

\_\_\_\_\_

Patient

\_\_\_\_\_

Date