

# NEW LONDON CANCER CENTER

Breast Health Clinic • Coagulation Clinic • Crossroads Infusion Center  
Crossroads Professional Building, 196 Parkway South, Suite 303, Waterford, CT 06385  
Ph: 860-443-4455 • Fax: 860-447-8961 • www.newlondoncancercenter.com

## PATIENT INFORMATION

PLEASE PRINT

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME # ( ) \_\_\_\_\_ WORK # ( ) \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

### IN CASE OF AN EMERGENCY, WHO CAN WE CONTACT?

NAME \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_

NAME \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_

### IF MARRIED, FILL IN SPOUSE'S INFORMATION. IF YOU ARE A MINOR, FILL IN PARENT INFORMATION.

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ WORK # ( ) \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

OTHER DOCTORS CARING FOR YOU \_\_\_\_\_

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization for release of medical information is given for Mithlesh Govil, MD/Stephen C. Lattanzi, MD/ Naeem Tahir, M.D. to release all information from my edical/psychiatric/alcohol/drug/HIV related medical records to the third party, which carries my health insurance, and to any entity, which is under my contract with such third party for the purpose of reviewing my medical care and treatment of the patient. I further authorize Mithlesh Govil, MD/Stephen C Lattanzi, MD and Naeem Tahir, M.D. to release information from my records described above to other medical care facilities/ Pharmaceutical companies for sole purpose of covering or obtaining drug and/or health care agencies and any physician participating in my medical care.

I can withdraw this consent at any time by giving written notice.

A copy of this signature is as valid as the original.

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

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## BILLING / INSURANCE INFORMATION

PATIENT'S NAME \_\_\_\_\_  
DO YOU HAVE INSURANCE COVERAGE?    YES            NO  
INSURANCE COMPANY NAME;  
PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_  
INSURANCE IDENTIFICATION NUMBERS:  
PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

Insured by: self Yes  Other

**If insured under other than self please provide additional information)**

NAME OF INSURED: \_\_\_\_\_  
RELATIONSHIP TO YOU: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOC. SEC. # \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

- I HEARBY AUTHORIZE THE RELEASE OF COPIES OF MY MEDICAL/ PSYCHIATRIC/ALCOHOL/DRUG/HIV RELATED MEDICAL RECORDS AND NECESSARY INFORMATION TO MY INSURANCE COMPANY, ANY PHYSICIAN PARTICIPATION IN MY MEDICAL CARE, MEDICAL CARE FACILITIES, AND/OR HEALTH CARE AGENCIES.
- I CAN WITHDRAW THIS CONSENT AT ANY GIVEN TIME BY GIVING A WRITTEN NOTICE.
- I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY MITHLESH GOVIL, M.D./STEPHEN C. LATTANZI, M.D./ NAEEM TAHIR, M.D., AND STEPHANIE C. MURON, PA-C
- I AUTHORIZE MITHLESH GOVIL, M.D./SHEPHEN LATTANZI, M.D./ NAEEM TAHIR, M.D., AND STEPHANIE C. MURON, PA-C, TO FILE TO MY INSURANCE COMPANY
- I AUTHORIZE MITHLESH GOVIL, M.D./STEPHEN C. LATTANZI, M.D./ NAEEM TAHIR, M.D., AND STEPHANIE C. MURON, PA-C, TO DEPOSIT CHECKS RECEIVED ON PATIENT'S ACCOUNT WHEN MADE OUT TO THE PATIENT.
- A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

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Date \_\_\_\_\_

Patient: \_\_\_\_\_

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

Claim Group: \_\_\_\_\_

SS# / ID#: \_\_\_\_\_

I hear by instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

NEW LONDON CANCER CENTER  
Crossroads professional Building  
196 Parkway South, Suite 303, Waterford CT, 06385

**OR**

If my current policy prohibits direct payment to doctor, I hear by also instruct and direct you to make out the check to me and mail it as follows:

NEW LONDON CANCER CENTER  
Crossroads professional Building  
196 Parkway South, Suite 303, Waterford CT, 06385

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

**Summary of Privacy Policy**  
**New London Cancer Center**  
**Crossroads Professional Building, 196 Parkway South, Suite 303, Waterford, CT 06385**  
**860-443-4455**

**Mithlesh Govil, M.D., Compliance Officer**

The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices (the "Notice") is available for your review. This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

- 1. Uses and Disclosures of Your Health Information: We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcription service, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.**
- 2. Other Uses and Disclosures: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.**
- 3. Your Health Information Rights: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:**
  - a. You may request restrictions on certain uses and disclosures of your information**
  - b. You may request that you receive your information from us in a certain way**
  - c. You may inspect and copy your medical records**
  - d. You may request an amendment to any record you believe is inaccurate**
  - e. You may request an accounting of disclosures made of your records**
- 4. Changes to the Notice: We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.**
- 5. Complaints: You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.**

**Policy has been made available to me for review.**

Signature: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Name : \_\_\_\_\_ Date: \_\_\_\_\_

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## RELEASE OF MEDICAL INFORMATION

Name: (First): \_\_\_\_\_ (Last): \_\_\_\_\_ (MI): \_\_\_\_\_

Date of Birth: (mm/dd/yy) \_\_\_\_\_

SS #: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Please provide the following information for your durable **Power of Attorney** (Person responsible for your affairs should you become unable to do so):

Name: (First): \_\_\_\_\_ (Last): \_\_\_\_\_ (MI): \_\_\_\_\_

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

Telephone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Please provide the following information for your **Conservator/Medical Health Care Agent** (Person responsible for your medical decisions should you become unable to do so):

Name: (First): \_\_\_\_\_ (Last): \_\_\_\_\_ (MI): \_\_\_\_\_

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

Telephone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Please list the names of people you **AUTHORIZE** us to release your medical information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Please list the names of people you **DO NOT AUTHORIZE** us to release your medical information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Pt. Ints: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# GUIDE FOR PATIENTS

New London Cancer Center

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<b>Crossroads Professional Building</b>	<b>Office Hours</b>
<b>196 Parkway South, Suite 303, Waterford, CT 06385</b>	<b>Monday – Friday 8 to 5:30 PM</b>
<b>Phone: 860-443-4455 • Fax: (860) 447-8961</b>	<b>Weekends &amp; Holidays 10-10:30 AM</b>

## **Scheduling appointments**

To schedule all appointments, please call the office at 443-4455. We reserve the right to charge \$25 for each missed or cancelled appointment if you give less than 24 hours notice.

## **Medical questions – telephone procedure**

All calls should be directed to the office at 443-4455 before 5:00 p.m. Please state the nature and urgency of your problem when calling. All non-urgent calls will be answered before 5:30 pm on regular business days. If you have an emergency, please ask for a nurse so that we may respond immediately.

## **Procedure for evenings, weekends, and holidays**

For emergencies, please call 443-4455. Please select the option to reach the on call physician. If your call is an emergency and the physician does not respond immediately, please contact the Emergency Room physician at Lawrence and Memorial Hospital 444-5140. If your call is not an emergency, please try to contact us during regular business hours.

## **Prescription refills**

Please have all your prescriptions written by your physician at the time of your appointment. Prescriptions for narcotics cannot be given outside of regular office hours or over the phone. An appointment must be scheduled to obtain narcotic prescriptions. Please ensure during the appointment that you have an adequate supply of medications until your next appointment, and particularly to cover weekends and holidays.

## **Insurance information and referrals**

We participate in Medicare and several managed care plans. Please notify us of any change in your insurance prior to your visit. You also have the sole responsibility to be sure the necessary referrals are in place before your visit. We are not responsible for any delay in your visit or any non-payment of services if you have not obtained the necessary referral paperwork before your visit.

## **Payment policy**

All co-pays are payable at the time of your visit. We collect co-pays PRIOR to your visit with the doctor. We reserve the right to add a \$5 surcharge to your bill each time you are unable to pay your co-pay at the time of your appointment. We accept cash and checks, but do NOT accept credit cards. Please keep this information in mind before your appointment. Timely payments keep all of us from having to spend unnecessary time on this issue and leave us free to respond to your medical needs.

## **Services provided**

Our practice provides laboratory services, education, chemotherapy, psychosocial counseling, nutritional services, and coordination of care with outside agencies, such as Hospice or a VNA, in a friendly, caring environment. We are continually striving to meet your needs. Please let us know if we can improve our services in anyway. We appreciate the opportunity to be of service to you.

Clinicians & Staff at

New London Cancer Center,

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