



**cancer  
services**  
OF GRANT COUNTY  
*Helping People Face Cancer*

## New Client Registration Form

*All information is kept secure and will not be sold or shared.*

*The more information we have about you, the more we can help you.*

What can we do to help you? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ (M or F) Last Four of SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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

Parent's Name (if minor): \_\_\_\_\_

Employer: \_\_\_\_\_ Retired From: \_\_\_\_\_

Insurance/Medicare/Medicaid \_\_\_\_\_ Policy Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Number of Minor Children at Home: \_\_\_\_\_

Emergency Contact that Does Not Live With You:

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

Type of Cancer: \_\_\_\_\_ Doctor: \_\_\_\_\_

Treatment:  Chemo  Radiation  Surgery

Treatment Center:  Marion  Muncie  Fort Wayne  Kokomo  Indy

Are You a Veteran? Y or N \_\_\_\_\_ Do You Receive VA Benefits? Y or N \_\_\_\_\_

Do You Have a Family History of Cancer? Y or N \_\_\_\_\_ If Yes, What Kind? \_\_\_\_\_

*Cancer Services of Grant County provides assistance FREE OF CHARGE. We are supported by donations and memorials from kind-hearted people here in Grant County.*

*If you would be interested in providing a testimony for our fundraising efforts, we could use your testimonial on our website, our Facebook page, or other media.*

Monthly Income		Monthly Expenses	
Wages:	\$	Mortgage Payment:	\$
Social Security:	\$	Car Payment:	\$
Retirement:	\$	House Insurance:	\$
Disability:	\$	Car Insurance:	\$
Child Support:	\$	Electricity:	\$
Other Income:	\$	Heat:	\$
		Water:	\$
		Telephone:	\$
		Other:	\$

**Affirmation**

I affirm all the information provided herein is true and correct to the best of my knowledge. I give Cancer Services of Grant County permission to disclose and receive information related to my case with associated providers as deemed necessary to assist you.

**RELEASES**

**Transportation**

I hereby relieve **Cancer Services of Grant County, Inc.**, its personnel and its volunteer drivers of any and all liability in the course of transportation assistance and, therefore, release them from all responsibility.

**Supplies / Equipment**

I hereby relieve **Cancer Services of Grant County, Inc.**, and all its personnel, of any and all liability concerning their services rendered on named client's behalf. **Cancer Services of Grant County, Inc.** will not be held responsible for any misuse or malfunctioning, or sterility of any and all equipment loaned to named client. I understand it is my responsibility to disinfect with an anti-bacterial cleanser said equipment pieces given to me to borrow. I agree to not take equipment to any nursing home facility. If a change of address occurs, I will notify Cancer Services of my new address and telephone number promptly. I will be personally responsible for the return of all equipment. I agree to bring back all parts belonging to the equipment, clean them with disinfectant, and return

during office hours, Monday-Friday, 9:00-4:00.

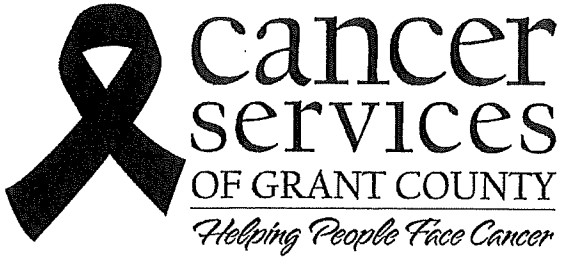
**All Claims**

The undersigned, being of lawful age, for good and valuable consideration, does hereby and for her heirs, executors, administrators, successors and assigns release, acquit and forever discharge **Cancer Services of Grant County, Inc.**, its employees, agents, representatives, and all other persons, firms, corporations, associations or partnerships (hereinafter referred to as the "released parties") of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has or in the future as a result of services provided to the undersigned by **Cancer Services of Grant County, Inc.**

I freely request assistance and therefore release **Cancer Services of Grant County** from all responsibility

Printed Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Staff Witness: \_\_\_\_\_



## Authorization for Release of Medical Information

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

Maiden Name: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

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

The undersigned hereby authorizes any and all health care providers and medical facilities to release records, based on the specific needs of the client, including:

- \_\_\_\_\_ History & Physical Report
- \_\_\_\_\_ Operative Report
- \_\_\_\_\_ Laboratory Report
- \_\_\_\_\_ X-Ray Report
- \_\_\_\_\_ Pathology Report
- \_\_\_\_\_ Any Additional Medical Records
- \_\_\_\_\_ Billing & Financial Information

**Release this information to:**

CANCER SERVICES OF GRANT COUNTY  
305 South Norton Avenue – Marion, IN 46952  
Phone: 765-664-6815 Fax: 765-664-1636

**The medical record is requested for the following purpose:**

At the request of the client, in order to better serve and assist with the needs of this client.

I understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS, or AIDS-related and/or communicable disease information may also be released. I also understand the released information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law.

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

Staff Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

