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:** _____

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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:** _____