-2200 West 1st Street, Sanford, FL 32771-

-52 West Gore Street, Orlando, FL 32806-

Phone Number: 407-321-3040
Fax Number: 855-235-4945

Name of Patient/Client: ____

SS#: ____ DOB:_______________________________________

Address: ____

City: ____ State: ____________ Zip: _____________________

INSTRUCTIONS: This authorization must be signed by the client, or by the legal guardian or person responsible in the case of a minor or when the client is physically or mentally incompetent.

NOTICE OF PRIVACY PRACTICES

I have received Radiation Oncology Consultants, P.A.'s Notice of Privacy Practices.

MEDICAL RELEASE CONSENT

I authorize Radiation Oncology Consultants, P.A. to speak to the following person(s) in regards to my medical condition/treatment:

____ ____
Name of Person Relationship

____ Leave Detailed Message: **YES/NO**
Phone Number

AUTHORIZATION FOR PHOTOGRAPHIC DOCUMENTATION

BE IT KNOWN that the undersigned hereby releases and authorizes Radiation Oncology Consultants, P.A. to incorporate photographs of and/or including the undersigned to be utilized in the patient's medical record for documentation, educational purposes and for physician consultation.

RELEASE AUTHORIZATION / FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

STATE OF FINANCIAL RESPONSIBILITY: I agree to pay RADIATION ONCOLOGY CONSULTANTS for any and all charges for services rendered. All accounts are due and payable with thirty (30) days of the date of billing unless other arrangements have been made. I understand that RADIATION ONCOLOGY CONSULTANTS will attempt to collect the assigned insurance benefits; however, the full amount will still be my responsibility. I realize the group may take whatever steps necessary to collect the balance due, including the use of a collection agency. In the event of any litigation concerning my failure to pay all charges for services rendered to me by RADIATION ONCOLOGY CONSULTANTS then I agree to pay to RADIATION ONCOLOGY CONSULTANTS the costs and expenses incurred by RADIATION ONCOLOGY CONSULTANTS in connection with its efforts to collect from me or its services rendered including but not limited to, reasonable attorney's fees both at the trial level and any appellate proceeding. In the event of any litigation between me and RADIATION ONCOLOGY CONSULTANTS I agree that venue and jurisdiction of such litigation shall lie exclusively in the state courts of competent jurisdiction located in and for *Orange/ Seminole* County, Florida.

AUTHORIZATION TO FILE MEDICAL INSURANCE: I grant permission to RADIATION ONCOLOGY CONSULTANTS to retain on file my signature as authorization to file my medical claims on my behalf.

Patient Initials:____________

ASSIGNMENT OF INSURANCE BENEFITS: I understand that RADIATION ONCOLOGY CONSULTANTS will file my insurance for me as a courtesy to me. RADIATION ONCOLOGY CONSULTANTS has no obligation to file for any insurance benefits on my behalf. In the event that RADIATION ONCOLOGY CONSULTANTS fails to properly file for any insurance benefits available to me, I understand that I shall remain fully responsible for all charge made by RADIATION ONCOLOGY CONSULTANTS for service rendered to me. I agree to send any and all payments and Explanation of Benefits directly to the billing department. In consideration of the services rendered by RADIATION ONCOLOGY CONSULTANTS, I assign to them the amount due to me or that becomes due to me under the policies mentioned. I authorize and direct that payment be made directly to RADIATION ONCOLOGY CONSULTANTS. I also recognize that should payment be made directly to me by the insurance company, the amount received up to my bill for services rendered is the property of RADIATION ONCOLOGY CONSULTANTS and should be paid over to said group immediately. I understand that I am personally liable to RADIATION ONCOLOGY CONSULTANTS for any charges not paid by this agreement.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize RADIATION ONCOLOGY CONSULTANTS to release any information regarding diagnosis and treatment requested by the insurance company necessary to collect benefits under the policies stated at the time of treatment, or any policies which I subsequently make claim against for radiation therapy.

I further authorize RADIATION ONCOLOGY CONSULTANTS to furnish any and all medical records or information which may be requested by a hospital or physician.

RELEASE OF INFORMATION TO RADIATION ONCOLOGY CONSULTANTS: I request that release of all requested medical records be made to RADIATION ONCOLOGY CONSULTANTS. This request extends to any and all radiology reports and films as deemed necessary by RADIATION ONCOLOGY CONSULTANTS.

GUARANTY (If Applicable)

I _____________________________________, husband/wife/___________________ of Patient, agree to pay RADIATION ONCOLOGY CONSULTANTS for the medical services rendered to Patient and to be legally obligated to pay Patient's debt under the terms set forth herein.

SIGNATURE OF SPOUSE OR GUARANTOR: ____

Agreement executed this ______________ day of ____________________________ 20_____________.

I have read and fully understand the above consents, and the explanations that were referred to in the consents.

____________________ ____

Date Signature of Patient or Patient's Legal Representative*

____

Relationship to the Patient*

*If Patient is a minor, or mentally incompetent–next of kin, legal guardian, or executor of the estate may sign.

____________________ ____

Date Witness, Where Applicable