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GENERAL CONSENT FOR TREATMENT

I, knowing that I am experiencing a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care to such medical, surgical, or other services under the general and specific instructions of Dr.________________________, his/her assistants or his/her designees as is necessary in his/her judgment.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr.________________________.

______________________________ ______________
Patient signature Date

OR

______________________________ ______________
Legal guardian signature Date

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Date

Location

Physician

Acct. #

For office use only

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES

Home phone (w/ area code)

Cell phone (w/ area code)

Patient name (last, first, MI)

E-mail address

Home address

City, state, zip code

Mailing address

City, state, zip code

Birthdate

Age

SSN

☐ Female ☐ Married ☐ Single ☐ Divorced

☐ Male ☐ Widowed ☐ Other

Employer

Occupation

Employer phone (w/area code)

Employer address

City, state, zip code

Referring physician

Primary care physician

Primary insurance

Insured's name

Insured's birthdate (month/day/year)

Group #

Policy #

Secondary insurance

Insured's name

Insured's birthdate (month/day/year)

Group #

Policy #

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology–San Antonio. I also authorize the release of any medical information and/or reports related to my treatment to any physician.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing/physician services, including major medical benefits, are hereby assigned to Texas Oncology–San Antonio. This assignment covers any and all benefits under Medicare, other government-sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event that my insurance carrier does not accept Assignment of Benefits, of if payments are made directly to me or my representative, I will endorse such payment to Texas Oncology–San Antonio.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Texas Oncology–San Antonio.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient signature

Date/Time

AM or PM

Responsible party signature

Relationship

Date/Time

AM or PM

Employee initials

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PATIENT ACKNOWLEDGMENT

I acknowledge that I have received a new patient information packet that includes a copy of the following:

- ☐ Patient Letter
- ☐ Rights and Responsibilities of Patients
- ☐ Advance Directive Information
- ☐ Notice of Privacy Practices

I have read and understand these documents.

Printed name of patient ______________________ Date ______________________

Patient signature ______________________

PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, ______________________________, hereby authorize Texas Oncology_San Antonio to use and disclose my health information in the manner described below. I understand that my health information may be re-disclosed by the persons or organizations receiving my health information from Texas Oncology–San Antonio, and that it may no longer be protected by federal and state privacy laws. I understand that I have a right to request and receive a Notice of Privacy Practices from Texas Oncology–San Antonio. *I voluntarily sign this authorization, and I understand that my ability to obtain healthcare from Texas Oncology–San Antonio will not be affected if I refuse to sign this authorization.*

1. Describe, specifically, the health information you are authorizing for use and/or disclosure by Texas Oncology–San Antonio including, dates and types of services:

____

____

____

2. The health information described above may be used and/or disclosed for the following purpose(s):

____

____

____

3. Persons or organizations that you authorize to use and/or disclose the health information described above:

____

____

____

4. Persons or organizations that you authorize to receive the health information described above:

____

____

____

5. This authorization expires upon ____________________(date or event that triggers expiration).

6. I understand that I may revoke this authorization at any time by notifying Texas Oncology–San Antonio in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization.

______________________________	______________________________
Signature of patient	Date

If authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

______________________________	______________________________
Name of personal representative	Relationship to patient

Distribution: Original>Medical Record; Copy>Patient or personal representative

AUTHORIZATION TO RELEASE MEDICAL AND BILLING RECORDS

I, ____________________, the undersigned, do hereby authorize

Name of physician	Address of physician

to release any and all medical and billing information from the medical records compiled during my term as his/her patient to the following:

Name of person records are released to	Address of person to receive records

I will notify Texas Oncology–San Antonio in writing regarding any changes/termination to this authorization.

Date signed

Signatures of patient OR person authorized to consent for patient