**POTOMAC RADIATION ONCOLOGY CENTER**

A SERVICE OF INOVA AND SENTARA HEALTHCARE

# *Authorization for Treatment, Claims and Payment*

***MEDICAL CONSENT*** – The undersigned consents to treatment and procedures which may be performed in this ambulatory care facility, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, or hospital service rendered the patient under the general and special instructions of the patient's physicians or surgeon. You have a right to know the identity of those providing patient care, to refuse any treatment, and to be informed of the possible medical consequences of refusal. Your signature on this document indicates your general consent to be treated. Your physician and/or members of the facility may request that you sign a more specific form relative to any procedure, which may be performed.

***AUTHORIZATION TO PROCESS CLAIMS & RELEASE OF INFORMATION*** – I authorize Potomac Radiation Oncology Center ("PROC") to process claims for payment by my insurance carrier(s) on my behalf for covered services rendered to me at "PROC". I authorize the release of necessary information, including medical information, regarding medical services rendered or any related services or claim, to my third party payer, including my insurance carrier(s), any managed care plan or any payer, past and/or present employer(s), Medicare, Champus, authorized private entities and/or utilization review entities acting on behalf of such third party payors, managed care plans and/or employer(s), the billing agents and collection agents, or attorneys of "PROC" and/or the independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and as applicable, the Social Security Administration, The Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or other federal or state agency for the purpose(s) of satisfying charges billed and/or facilitating utilization of review and/or otherwise complying with the obligations of state or federal law. A photocopy of this Authorization may be honored.

I also understand that certain physicians and surgeons, who render services to me, such as physicians on call, radiologists and others, may not be participating physician members of my managed care health plan. My plan may consider these services as non-covered services. Consequently, I understand that, in the event that my managed care health plan does not reimburse these non-participating physicians in full for services provided to me, my managed health plan may make me responsible for any balance that is declined to pay for such services.

I understand that this authorization may be revoked by me at any time in writing to the Patient Registration and Financial Services Department.

***NON-RESPONSIBILITY FOR PERSONAL PROPERTY*** – I understand that "PROC" cannot be responsible for any valuables, money, personal or other possessions which may be brought with me during my visits to this facility. "PROC" assumes NO responsibility for the safety of dentures, eyeglasses or hearing devices.

***ASSIGNMENT OF BENEFITS*** – I hereby assign and request payment from my insurance carrier or managed care plan, in any, directly to "PROC" and each of the independent contractor physicians and/or professional corporation that provide services for me. (In the case of Medicare Part B benefits, I request payment either to myself or the party who accepts assignment.) The direct payment hereby assigned and authorized includes any hospital and/or medical insurance benefits to which I am otherwise entitled, including any Major Medical Benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to "PROC", the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

***COORDINATION OF BENEFITS*** – I agree to provide "PROC" information regarding all group hospitalization, workers' compensation, or other benefits to which the patient may be entitled including the following information:

a) These are my primary and secondary policies by name and number:

**Primary insurance** ____________________________________________**ID#**_________________________**GR#**____________________

**Secondary insurance** ____________________________________________**ID#**________________________**GR#**____________________

b) I am covered under Medicare Yes No Medicare is my primary coverage Yes No

c) Policy holders Date of Birth_________________ Name __________________________________ Relationship______________

***RESPONSIBILITY FOR PAYMENT*** – In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs.

The undersigned certifies that he or she has read this form and understands its terms. The undersigned certifies that he/she has received a copy of it and that the undersigned is either the patient or is duly authorized to sign this form on behalf of the patient and accept its terms.

-

**X** **Sign**___________________________________**Print**____________________________ ____________________

**Patient (Guardian / Responsible Party)** **Date**

**X** ____________________________________________________________ ____________________

**Witness** **Date**

**Radiation Oncology Associates, P.C.**
Policy for Payment of Accounts

To prevent misunderstandings, please be advised that the patient is ultimately responsible for all bills. If you have insurance, under most circumstances, we will file the health insurance claim for you. However, THE PATIENT is responsible for all deductibles, copays and other allowable balances that his/her insurance does not pay. If you do not have health insurance and are not able to pay your bill in full, we do extend credit to our patients who need it. However, you must request to establish a payment plan before treatment commences.

If you are a member of a Health Maintenance Organization (HMO) or any other health plan that requires referrals and co-payments, it is the office policy to obtain both the referral(s) and the copay at the time you check in for your appointment. If you do not have the required referral(s) for your visit, you are financially responsible for the visit and any related services rendered.

If you do not have your insurance card with you when you register as a new patient, you will be considered as a private pay patient and will be financially responsible for the visit until such time the insurance card is presented to our office. You will be asked to sign a statement of responsibility since your insurance is filed as a courtesy.

Payment Agreement

I agree to pay all amounts for which I am responsible, including but not limited to insurance copays, deductibles, and all balances for which I have no insurance coverage. Further, should it be necessary to refer my account to a collection agency or attorney, I agree to the collection fees described below.

Signature ______________________________________________ Date _______________

Spouse's Signature _______________________________________ Date _______________

Assignment and Medical Information Release

I authorize the release of any medical or other information necessary to process medical claims for services furnished by Radiation Oncology Associates, P.C. I authorize the review of my medical records by my health plan for audit purposes.

I authorize payment of medical benefits to Radiation Oncology Associates, P.C. for any services furnished by that establishment through its providers for services as indicated/described on my insurance claim forms.

Patient's Signature _______________________________________ Date _______________

**FOR PATIENTS WITH MEDICARE**

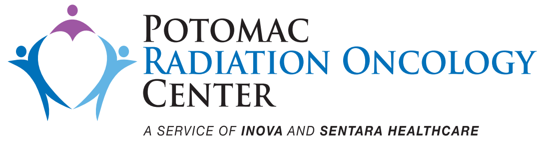
I request that payment of authorized Medicare benefits be made on my behalf to Radiation Oncology Associates, P.C. for any services furnished by that establishment. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature ______________________________________ Date ______________________

Collection Fees

If this contract or any debt owed to Radiation Oncology Associates, P.C. is referred for collection, I agree to pay all collection fees in the amount of thirty-three and one-third percent (33⅓%) of the total indebtedness and court costs incurred by Radiation Oncology Associates, P.C. I understand and agree that should Radiation Oncology Associates, P.C. be awarded judgment relating to this contract or any debt incurred thereof, I will pay a service charge of one and one-half percent (1½%) per month; eighteen percent (18%) per annum, beginning on the day of judgment.

Beneficiary Name ___________________________ Medicare Number ___________________________




I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at **www.inova.org.** I may request that a copy be mailed to me by calling 703-204-3342.

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

_______________________________________________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_______________________________________________
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_______________________________________________
DATE

_______________________________________________
DESCRIPTION OF PERSONAL REPRESENTATIVE AUTHORITY

Patient Name: ______________________________
Medical record #______________________________