Advanced Cancer Therapies

Patient Name: _____
Account Number: _____

Patient Authorization Form

Thank you for choosing Advanced Cancer Therapies as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you please read and sign this form to acknowledge your understanding of our patient financial and insurance policies.

Financial Responsibility- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of his/her treatment and care. As a patient, I agree to pay Advanced Cancer Therapies any and all charges for services rendered regardless of any assigned insurance benefits. Co-payments, estimated deductibles and coinsurances payments are due, in full, at the time of service.

Payment Options- I shall submit payment to Advanced Cancer Therapies by cash, check, or credit card. Special financing is available through Care Credit for those who qualify.

Authorization for Care- I grant Advanced Cancer Therapies permission to render care and treatment as my physician deems medically necessary. I understand that such care may include medical and surgical treatment, laboratory tests, diagnostic tests, i.e.: cystoscopy, IVP, biopsy or injection therapy; which may cause me to incur separate charges from other professionals related to these services.

Insurance Assignment- I hereby authorize direct payment of surgical/medical benefits to Advanced Cancer Therapies for services rendered. I understand that I am responsible for charges not covered by my insurance or Third Party Payors. I understand that it is my responsibility to comply with all precertification requirements per my insurance company.

Medicare Assignment of Benefits- I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to Advanced Cancer Therapies and authorize Advanced Cancer Therapies to submit claims to Medicare for payment. I understand that I am responsible for any health insurance deductible and coinsurance.

Authorization for Release of Information- Advanced Cancer Therapies is authorized to disclose necessary information from my medical record to the parties listed below when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third party payor for the purpose of obtaining payment for the services provided. Advanced Cancer Therapies, its employees, officers and physicians are released from legal responsibilty or liability for the release of the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV, and other diseases, all of which I specifically authorize to be so released.

*Parties **other than patient and patient's physician(s)** that are authorized to receive medical informaton:*

_____ Relation to patient_____
(please print)

_____ Relation to patient_____
(please print)

_____ Relation to patient_____
(please print)

Patient Privacy Act- I acknowledge that Advanced Cancer Therapies Notice of Privacy Practices has been offered to me and is available upon request at any time.

I have read, understand, and agree to the provisions of this Patient Authorization Form.

_____ _____ _____
Signature of Patient or Representative Relationship Date