

CONSENT TO TREATMENT

I, _____ hereby request and consent to medical evaluation and treatment by medical providers and staff employed by Northwest Georgia Oncology Centers, P.C. (NGOC). I understand that NGOC has physician assistants and nurse practitioners on staff and I have the right to request to see a physician prior to any prescription drug or device order being carried out by a PA or NP. I understand that I have the right to refuse, withdraw, or transfer the responsibility of my treatment at any time and agree to inform NGOC of any such decision. I agree to pay NGOC promptly any fees incurred for services rendered by NGOC and its employees.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that NGOC will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in NGOC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

Patient Signature _____ Date _____
Relationship to Patient (if not patient) _____ Date _____

ASSIGNMENT DECLARATION

I hereby authorize benefits to be assigned to the above listed healthcare provider. I hereby certify that the insurance information that I have provided is true and accurate as of the date of service and that I am responsible for keeping it updated. I understand that I am responsible for all copayments, coinsurance and deductibles that are not paid by my insurance carrier.

I hereby authorize Northwest Georgia Oncology Centers, P.C. to submit claims on my behalf. I understand and fully agree that the submission of a claim does not absolve me of my responsibility to ensure that the claim is paid by my insurance carrier.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental agency or attorney involved in this case. I authorize Northwest Georgia Oncology Centers, P.C. to by my personal representative, which allows them as my legally binding authorized representative to (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits plan.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient Signature _____ Date _____
Guarantor _____ Date _____

REQUEST FOR RELEASE OF MEDICAL RECORDS TO NGOC

I hereby authorize the release of any and all information concerning my medical care, diagnosis, prognosis and treatment (including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information) to Northwest Georgia Oncology Centers, P.C. This information is to be used by NGOC solely for my medical evaluation and treatment.

A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature of Person Providing the Authorization _____ Date _____
Relationship to Patient (if not patient) _____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for NGOC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). NGOC's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. NGOC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NGOC Privacy Officer at 531 Roselane St., Suite 650, Marietta, GA 30060.

With this consent, NGOC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, NGOC may e-mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that NGOC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to NGOC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, NGOC may decline to provide treatment to me.

Signature of Person Providing the Authorization _____ Date _____
Relationship to Patient (if not patient) _____ Date _____