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.

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X **Sign**_____ **Print**_____ _____

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

X _____ _____

Witness **Date**