Greater Houston Radiation Oncology: PATIENT POLICIES AND CONSENT FORM

Patient Name:_____ Date_____

The physicians of Greater Houston Radiation Oncology require this form to be signed by our patients. We appreciate your cooperation.

If you have any questions, please ask the receptionist.

1. **Financial Responsibility:**
   We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with GHRO and its affiliates. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to the front desk staff including any authorizations and/or referrals that are required by your insurance.

   Signature of Patient or Legal Guardian:_____

2. **Authorization to Release Information:**
   I hereby authorize GHRO and its affiliates to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

   Signature of Patient or Legal Guardian:_____

3. **Authorization to Pay Benefits to Physicians:**
   I hereby authorize payment for medical services provided to be paid directly to the physicians associated with GHRO and its affiliates.

   Signature of Patient or Legal Guardian:_____

4. **Please Read and Then Choose YES or NO:**
   If you are unavailable, may we leave medical information, such as confirmation of an appointment or an insurance/billing question on your answering machine or with someone at your residence?

   _____ **YES** - You may leave information as above.
   _____ **NO** - Do not leave any information with anyone.

   Signature of Patient or Legal Guardian:_____

5. **Acknowledgement of Receipt of Privacy Policy:**
   I acknowledge that I have read the Practice's Privacy Policy and a copy will be provided to me upon request.

   Signature of Patient or Legal Guardian:_____
   Date:_____

   Signature of Staff:_____ Date:_____

Updated March 2014