

**RADIATION ONCOLOGY CONSULTANTS, P.A.**  
**RELEASE AUTHORIZATION / FINANCIAL POLICY**

**PATIENT:** \_\_\_\_\_ **PHYSICIAN:** \_\_\_\_\_

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

**STATE OF FINANCIAL RESPONSIBILITY:** I agree to pay RADIATION ONCOLOGY CONSULTANTS for any and all charges for services rendered. All accounts are due and payable within thirty (30) days of the date of billing unless other arrangements have been made. I understand that RADIATION ONCOLOGY CONSULTANTS will attempt to collect the assigned insurance benefits, however, the full amount will still be my responsibility. I realize the group may take whatever steps are necessary to collect the balance due, including the use of a collection agency. In the event of any litigation concerning my failure to pay all charges for services rendered to me by RADIATION ONCOLOGY CONSULTANTS then I agree to pay to RADIATION ONCOLOGY CONSULTANTS the costs and expenses incurred by RADIATION ONCOLOGY CONSULTANTS in connection with its efforts to collect from me or its services rendered including, but not limited to, reasonable attorney's fees both at the trial level and any appellate proceeding. In the event of any litigation between me and RADIATION ONCOLOGY CONSULTANTS I agree that venue and jurisdiction of such litigation shall lie exclusively in the state courts of competent jurisdiction located in and for \_\_\_\_\_ County, Florida.

**AUTHORIZATION TO FILE MEDICAL INSURANCE:** I grant permission to RADIATION ONCOLOGY CONSULTANTS to retain on file my signature as authorization to file my medical claims on my behalf.

**ASSIGNMENT OF INSURANCE BENEFITS:** I understand that RADIATION ONCOLOGY CONSULTANTS will file my insurance for me as a courtesy to me. RADIATION ONCOLOGY CONSULTANTS has no obligation to file for any insurance benefits on my behalf. In the event that RADIATION ONCOLOGY CONSULTANTS fails to properly file for any insurance benefits available to me, I understand that I shall remain fully responsible for all charges made by RADIATION ONCOLOGY CONSULTANTS for services rendered to me. I agree to send any and all payments and Explanation of Benefits directly to the billing department. In consideration of the services rendered by RADIATION ONCOLOGY CONSULTANTS, I assign to them the amount due to me or that becomes due to me under the policies mentioned. I authorize and direct that payment be made directly to RADIATION ONCOLOGY CONSULTANTS. I also recognize that should payment be made directly to me by the insurance company, the amount received up to my bill for services rendered is the property of RADIATION ONCOLOGY CONSULTANTS and should be paid over to said group immediately. I understand that I am personally liable to RADIATION ONCOLOGY CONSULTANTS for any charges not paid by this agreement.

**AUTHORIZATION FOR RELEASE OF INFORMATION:** I authorize RADIATION ONCOLOGY CONSULTANTS to release any information regarding diagnosis and treatment requested by the insurance company necessary to collect benefits under the policies stated at the time of treatment, or any policies which I subsequently make claim against for radiation therapy.

I further authorize RADIATION ONCOLOGY CONSULTANTS to furnish any and all medical records or information which may be requested by a hospital or physician.

**RELEASE OF INFORMATION TO RADIATION ONCOLOGY CONSULTANTS:** I request that release of all requested medical records be made to RADIATION ONCOLOGY CONSULTANTS. This request extends to any and all radiology reports and films as deemed necessary by RADIATION ONCOLOGY CONSULTANTS.

**GUARANTY**

I \_\_\_\_\_, husband/wife/ \_\_\_\_\_ of Patient, agree to pay RADIATION ONCOLOGY CONSULTANTS for the medical services rendered to Patient and to be legally obligated to pay Patient's debt under the terms set forth herein.

Agreement executed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

**SIGNATURE OF PATIENT** \_\_\_\_\_

**SIGNATURE OF SPOUSE OR GUARANTOR** \_\_\_\_\_

**WITNESS** \_\_\_\_\_