PRINTED NAME: _____ **D.O.B.**_____

AUTHORIZATION FOR RELEASE AND USE OF CONFIDENTIAL PATIENT HEALTH INFORMATION

At **Hematology Oncology Consultants Ltd.**, we are committed to treating your protected health information responsibly. You may review our Notice of Privacy Practices, displayed in both the office locations, or request a print copy at the time of your visit. Signing below acknowledges that you have reviewed the policy and find it acceptable.

Signed:_____ Date:_____

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INSURANCE AND PATIENT FINANCIAL RESPONSIBILITIES

I understand that as recipient of medical care, I, the undersigned, am responsible for all charges for the services rendered, not withstanding any contracts I may have with any third party (e.g. Insurance Company). I understand that I will pay all co-pays at the time of service as this is a contractual agreement between you and your Insurance. All patient balances due are payable to the Provider upon request.

I understand that it is my responsibility to know the terms of my Insurance and keep in compliance with them including but not limited to ensuring that a current insurance card is provided at time of service and/or referral form for each visit. I am responsible for all visits and procedures not properly authorized.

If I have no Insurance, it is my responsibility to discuss and finalize any financial arrangements before services are rendered.

If I am unable to pay the total balance due at the completion of each service, it is my responsibility to contact the billing office and set up a reasonable payment plan.

Signed: _____ Date: _____

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I authorize the release of all medical records to any physician involved in my care and to my insurance company, if applicable.
I authorize fax transmittal of all medical records if necessary.
I authorize the payment of my medical bills to the Physicians by my Insurance Company.

Signed:_____ Date: _____