Consent to Treat

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services at The Center for Cancer and Blood Disorders provided by physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures (such as lab and x-rays), examinations, and treatment that may include chemotherapy and/or radiation therapy.

RELEASE OF INFORMATION: I authorize The Center for Cancer and Blood Disorders to disclose my health information for the purpose of continued care, claims processing or other related needs. I authorize The Center to obtain health records from other providers as needed for my continued care. Any other use of this information requires written consent.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare, Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to The Center for Cancer and Blood Disorders. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and heath care charges, to The Center for Cancer and Blood Disorders. I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by The Center for Cancer and Blood Disorders.

I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct and that it is my responsibility to notify The Center of changes to my address, telephone number, primary care physician, or insurance carrier. __________ (Patient's Initials)

I **(do) (do not)** consent to photographs or other audiovisual recordings related to my health record.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

ADVANCE DIRECTIVE: I have signed an Advance Directive. ____ YES ____ NO (Patient's Initials)
If yes, is it still in effect? ____ YES ____ NO
I have provided a signed copy to The Center for Cancer and Blood Disorders. ____ YES ____ NO

NOTICE OF PRIVACY PRACTICES: I have received a copy of The Center for Cancer and Blood Disorders' Notice of Privacy Practices. __________ (Patient's Initials)

______________________________/____________________________
DATE TIME

____ ____
Patient/Other Legally Authorized Person Witness/Translator*

____ ____
Print Name and Relationship to Patient Print Witness Name and Translated Language