



## GENERAL CONSENT FOR RCCA SERVICES

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical services (examinations, testing and treatment) in person or remotely by phone, video, text messages and via the internet. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent is for all necessary services including evaluation and management in the office and in other facilities you may be admitted to/treated at from time to time, chronic and principal care management, transition of care management discussions, and other necessary services and will remain fully effective until it is revoked in writing.

You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

- I consent to the necessary treatment and diagnostic tests my physician orders for my care.
- I authorize the release of all medical records to the referring, consulting and family physicians and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I acknowledge responsibility for services rendered by a division of Regional Cancer Care Associates LLC.

- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Co-pays are due at the time of service per your health insurance policy.
- I further authorize and request that insurance payments be made directly to Regional Cancer Care Associates LLC should they elect to receive such payment.
- I have received information on Advance Directives and will discuss this with my physician, (you will receive a copy from our receptionist at your appointment).

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, INSURANCE AUTHORIZATION AND INFORMATION ON ADVANCED DIRECTIVES.

Signature	Date
Printed Name	Date of Birth

**NOTICE TO PATIENTS REGARDING CO-PAYS**

To eliminate any confusion regarding co-pays and your responsibilities as our patient, please read the following:

- Co-pays are due at the time of service; we are required to collect your co-pay if your insurance states you have one.
- We accept cash, checks and credit cards.
- We do not “bill you” for your co-pays; it is expected that co-pays be paid at the time you are seen in the office.
- Your health insurance plan deducts your co-payment from the payment they send us in expectation that we collect your co-pay.



- We are in violation of our contract with your health insurance plan if we do not collect your co-pay. Co-pays apply when you see the physician, APRN or PA. They may apply when you see the nurse.
- Any questions regarding your co-pay or insurance questions should always be directed to our Business Office.