MEDICAL ONCOLOGY AND BLOOD DISORDERS, LLP
A division of REGIONAL CANCER CARE ASSOCIATES LLC

CHARANJEEV S. KAPOOR, MD •JOSEPH F. MCLAUGHLIN, MD • MOHAMMAD PAZOOKI, MD
MICHAEL A. REALE, MD, PhD • JOEL S. SILVER, MD

- 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 Medical Oncology and Blood Disorders, LLP, 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