Patient Name: ____ Today's Date__________________
Last *First* *M.I.*
Home Address: ______________________________________Mailing Address: ____________________________
Street *Street*
____ _____________________________________
City *State* *Zip* *City* *State* *Zip*
Phone: ________________________ _____________________ _________________________________
Home *Work* *Mobile*
DOB: ____________Age _________ __M __F SS# _________________ M S D W Other________________
Circle Marital Status
Employer: ____ ( ) _________________________
Name *Telephone*
____
Address *Occupation*
Responsible Party: ______________________ ____________________ __ ( )_________________________
Name *Relationship* *Telephone*
Emergency Contact:
Spouse/Next of Kin:_____________________ _______________________( )_________________________
Name *Relationship* *Telephone*
Referring Physician: _____________________________ Primary Care Physician: ____

Primary Ins:______________________________________ Telephone:_(____)___________________________
Insured Name: ______________________________ DOB:_________ Group#:___________Policy#:_____________
Secondary Ins: ____________________________________ Telephone :_(____) ___________________________
Insured Name: ______________________________ DOB: _________ Group#___________ Policy#:_____________

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1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Generations Radiotherapy & Oncology PC (GenXRT), I also authorize agent(s) of any hospital, treatment center of previous physicians to furnish GenXRT copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and /or reports related to my treatment to any federal, state or accreditation agency, or any physicians or insurance carrier as needed. I also agree to a review of medical records for purposes of internal audits, research and quality assurance reviews within GenXRT.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing /physicians services including major medical benefits are hereby assigned to GenXRT. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to GenXRT.
4. I understand that my patient information arising out of my medical treatment and records made by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companied and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefits plan; (f) persons conducting quality or peer review or patient satisfactions surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with GenXRT.
5. **PERSONAL VALUABLES**: I acknowledge that GenXRT shall not be liable for the loss or damages of any personal property.
6. **CONSENT FOR PHOTOGRAPH**: I, the undersigned, give GenXRT, its physicians and staff, permission to make photographs of me for placement into my clinical record.
7. **PATIENT'S BILL OF RIGHTS AND RESPONSIBITIES**: See back of form.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read the above statements and accept these terms. A duplicate of the statement shall be considered as valid as the original.

____ ____
Patient Signature **Date**

____ ____
Responsible Party Signature **Relationship** **Date**

WHITE COPY GENXRT - YELLOW COPY PATIENT