Acknowledgement of Receipt of Notice of Privacy Practices

With my signature below, I acknowledge receipt of the
Alliance Oncology
Notice of Privacy Practices

Name

X

Signature

If personal representative, please provide name and relationship to patient
(e.g. guardian, parent of child under 18)

Date

Medical Record Number

Radiation Oncology, Suite 1001
1 Wallace Bashaw Jr. Way
Newburyport, MA 01950
Main number: 978-997-1351
Fax:978997-1352

ALLIANCE RADIATION ONCOLOGY at ANNA JAQUES HOSPITAL

Patient's Name: _____ Date of Birth: _____

Address: _____

I hereby authorize _____
Name of Physician, Facility or person

Located at _____
Street *City* *State* *Zip*

To release protected health information, contained in the medical record of the above-named patient to the following facility:

Alliance Radiation Oncology at Anna Jaques Hospital
Radiation Oncology, Suite 1001
1 Wallace Bashaw Jr. Way
Newburyport, MA 01950
Main number: 978-997-1351
Fax: 978-997-1352

Information to be released:

Dates of Treatment to be Released: _____ to _____ ☒ Laboratory Result ☒ Imaging (Reports Only)

☒ Office Notes: _____ ☒ Pathology ☒ Complete Record
Specify Clinician(s)

☒ Other: _____

Purpose of Release: ☒ Medical Care ❑ Other: _____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not re-disclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

I understand that I may refuse to sign or revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above

X _____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to patient or authority to act for patient

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Authorization to Release/Receive Information

Your health information is protected by the "Health Insurance Portability and Accountability Act" (HIPAA) and as a result, we cannot discuss any personal information with family or friends unless you give us permission.

Please list the names of persons we are allowed to speak with and what relation they are to you. Please let them know they must be able to verify your name, social security number, and birthday ***before*** any information may be released.

1 _____ **Relation:** _____ Ph# ( ) -

2 _____ **Relation:** _____ Ph# ( ) -

3 _____ **Relation:** _____ Ph# ( ) -

4 _____ **Relation:** _____ Ph# ( ) -

5 _____ **Relation:** _____ Ph# ( ) -

Please list if you have any requests for restrictions to your protected health information:

1 _____ **Relation:** _____

2 _____ **Relation:** _____

If you have any questions, please see the "Notice of Privacy Practices" form or ask the office staff.

Thank you.

Patient's Name _____ **MR#:** _____

Patient's Signature _____ **Date** _____

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
(A COPY SHALL BE VALID AS THE ORIGINAL)

Please read the following information as it applies to you. During the course of radiation therapy treatments, you will receive a statement from {Config.Inst_Name} for the services performed. We will file all insurance claims in our office and the insurance companies will send payments directly to us for our services provided to you. We will also file any secondary insurance if you have other coverage.

Some services may not be covered by your insurance for which you will be responsible; also, services are only covered as long as you are eligible according to your insurance plan.

We will accept the Medicare allowed amount for services, however; **Medicare pays 80%** of eligible charges, and **the patient is responsible for the remaining 20%,** unless you have a secondary insurance, which we will be glad to file for you. All other insurance's pay according to the plan you have during your eligible dates, **which may leave a balance for which you may be responsible.** If you have any questions regarding you plan, please call your insurance company. We want to help you understand our billing procedures and will be happy to assist you in any way we can. If you have any questions regarding your account with us, **please call our billing office at 1-866-964-4959.**

It is extremely important that you keep us informed of any changes in your insurance coverage as soon as possible.

MEDICARE
I authorize Alliance Oncology to release any information needed to the Social Security Administration or its intermediaries or carriers for the purpose of filing claims. I request that my insurance payments be made directly to Alliance Oncology for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

MEDICAID
I authorize Alliance Oncology to release any information needed to the Medicaid intermediary or carrier for the purpose of filing claims. I request that payment of benefits be made directly to Alliance Oncology. I acknowledge that I am financially responsible for any services provided on date for which I am not Medicaid eligible as well as any spend down amounts.

INSURANCE CARRIER
I authorize Alliance Oncology to release any information needed to my insurance carrier for the purpose of filing claims. I authorize the insurance payments be made directly to Alliance Oncology for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

X _____ **MR#:** _____

Signature of patient or authorized Representative **Relation to patient**

_____ _____

Physicians Representative **Date Signed**

Alliance Radiation Oncology does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs.

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