RADIATION ONCOLOGY CARE
AT MERIDIAN PARK

Patient Responsibility Disclaimer

Patient Name: _____ DOB: _____

Non-Referred visits to a Specialty Provider are your responsibility.

I, _____, understand that in order to cover services provided, my insurance may require a referral from my primary care provider. I also understand that if Radiation Oncology Care at Meridian Park has not received authorization for a referral from my primary care provider, or if my insurance does not pay for my medical services, I will be financially responsible for any and all charges incurred.

Designation of Authorized Representative:

I, _____, hereby grant Radiation Oncology Care at Meridian Park (ROCAMP) the authority to act as my authorized representative in all matters related to treatments and services I received at their facility. This designation includes the authority to investigate and appeal any and all issues pertaining to medical and financial matters concerning service provided by ROCAMP and its associated physicians and providers.

Assignment of Insurance Benefits:

I hereby agree to full responsibility for all expenses incurred by or on account of this patient, and hereby assign to Radiation Oncology Care at Meridian Park any and all insurance benefits due to me to the full extent of my financial obligations to said clinic.

Authorization to Release Information:

I hereby authorize Radiation Oncology Care at Meridian Park to release to my insurance company any acquired information in the course of my examination or treatment.

Patient/Patient Representative Signature:

By signing below, I acknowledge that I have read and understand the above statements. A photo-static copy of this authorization shall be considered as effective as the original

Patient or Legal Representative Signature: _____

Relationship: _____ Date: _____

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