Patient Acknowledgement and Consent
for Health Information Disclosure, Evaluation, Treatment, and Billing

1. I understand that Community Cancer Foundation, dba Community Cancer Center and OHSU Department of Radiation Medicine (referred to below as "this Practice") will use and disclose **health information** about me as described in the **Notice of Privacy Practices** provided to me. I have received a copy of the **Notice of Privacy Practices** and have reviewed and understand the information included in it.
2. I grant permission for the Community Cancer Center and it's providers to evaluate and/or treat the above named patient.
3. I authorize this Practice to obtain prescription history information through the Pharmacy Benefit Manager. This monitoring allows the Practice to receive all current prescriptions that you have been prescribed by any of your providers within the last 12 months
4. I authorize payment to be made to this Practice for services provided.
5. **Copays are due at the time of service.** As a courtesy, we will bill your primary, and one secondary, insurance. However, **payment will be expected in full from the patient within 30 days after the patient's responsibility has been determined**, unless other payment arrangements have been made. If the provider is PARTICIPATING with my insurance carrier, I am only responsible for deductibles, co-insurance, and any non-covered services. If the provider is NON-PARTICIPATING with my insurance carrier, I am responsible for my account in full. Those patients undergoing radiation therapy will have individual financial counseling during their treatment period with estimated patient responsibility presented.
6. **CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:** Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

   ________ (Initial) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize the practice to send text messages for appointment reminders, feedback, and general health reminders/information to provided cell phone number. Standard text messaging rates may apply as provided in your wireless plan.
   ________ (Initial) I authorize the practice email/text messages for appointment reminders and general health reminders/feedback/information if email is provided.

   Cell Phone: ______________________________ Email: ____

By signing below, I agree that I have reviewed and understand the information above.

Patient Signature:	Printed Name:	Date:

If applicable, Patient Representative:

Patient Representative's Signature:	Printed Name:	Date:
Description of Representative's Authority:		