CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: ______________________________ **DOB:**_______________

Please check one of the following:

❑ **I give permission to the employees of Gynecologic Oncology of Tallahassee, a division of Florida Cancer Specialists to disclose my Protected Health Information to me and the following individual(s):**

Name: ______________________________ Relation:______________ Phone: _______________

Name: ______________________________ Relation:______________ Phone: _______________

Name: ______________________________ Relation:______________ Phone: _______________

Name: ______________________________ Relation:______________ Phone: _______________

Name: ______________________________ Relation:______________ Phone: _______________

Name: ______________________________ Relation:______________ Phone: _______________

❑ I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

______________________________ ______________________
Patient Name (Print) Date

____
Patient or Guarantor (Signature)

FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Gynecologic Oncology of Tallahassee, a division of Florida Cancer Specialists (GOT/FCS), as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide GOT/FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that GOT/FCS will bill your insurance plan or program for services provided by GOT/FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to GOT/FCS and you are authorizing payment to be made directly to GOT/FCS.
- You agree you are responsible for payment to GOT/FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, GOT/FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of GOT/FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- GOT/FCS owns and operates RX To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your GOT/FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use RX To Go and may have your prescriptions filled wherever you choose. However, if you select RX To Go to fill GOT/FCS-issued prescriptions, then this policy and all other GOT/FCS patient financial responsibility policies will also apply to the items and services provided to you by RX To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by GOT/FCS clinicians at GOT/FCS's own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to GOT/FCS that results in a surplus on your account (i.e., a credit balance), GOT/FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and GOT/FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, GOT/FCS will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PATIENT FINANCIAL POLICIES. A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST.

Patient Name (Print) Date

Patient or Guarantor (Signature)

For office use:

Name (Print) Date

Gynecologic Oncology of Tallahassee/FCS Employee (Signature)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Gynecologic Oncology of Tallahassee, a division of Florida Cancer Specialists, (GOT/FCS) Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any GOT/FCS facility or by submitting a request in writing to the corporate office at Gynecologic Oncology of Tallahassee, a division of Florida Cancer Specialists, Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting **GYNONCofTally.com/policies/GOT_NPP.pdf**

Date:________________

____ ________________________
Patient Name (Print) DOB

____ ________________________
Patient (Signature) Date

____ ________________________
Patient or Guarantor (Signature) Date

By signing below, I authorize Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists, (GOT/FCS) (and any authorized GOT/FCS texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by GOT/FCS under my cell phone plan.

I know that I am under no obligation to authorize GOT/FCS to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP".

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

____ ____________________

Patient Name (Print) Date

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Patient (Signature)