



Bay Area Gynecology Oncology (BAGO) Patient Consent Agreement Form, Page 1 of 2

I agree to the following two pages of terms for receiving care through Bay Area Gynecology Oncology:

_____/_____/_____
PATIENT NAME PATIENT DATE OF BIRTH

_____/_____/_____
PATIENT SIGNATURE SIGNATURE DATE

<u>GUARDIAN ONLY BOX</u>		
_____ GUARDIAN NAME	_____ GUARDIAN SIGNATURE	_____/_____/_____ SIGNATURE DATE

CONSENT FOR TREATMENT

I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. This may include the administration of needed anesthetics, the use of prescribed medication, the use of diagnostic procedures and the use of x-rays and laboratory test.

RELEASE OF INFORMATION

I authorize the release of any medical information to and from any medical facilities, physicians, and/or my insurance company. I also authorize the following person(s) to receive any of my medical information:

MEDICAL RECORDS AND RX HUB INQUIRY

I consent to Bay Area Gynecology Oncology obtaining any/all of my medical records and my Rx history using any system including the Sure Scripts-Rx Hub Network to provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that Sure Scripts-Rx has certified Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy.

PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have been given **The Notice of Privacy Practices** for Bay Area Gynecology Oncology.

TRANSLATION

I authorize the following person(s) to provide translation services: _____

REFERRAL/AUTHORIZATIONS

I agree to provide a referral or an authorization from my Primary Care Physician (PCP) or referring physician if my insurance is an HMO at the time of my visit. If no referral form is provided, my visit may be re-scheduled.



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PAYMENT

I understand that I am responsible for payment for services including co-payments, balances and charges for services not covered by insurance. All payments are due at the time of service. I authorize the payment of insurance benefits to one of the following, James Lilja, M.D., Katherine Volpe, M.D., or Bay Area Gynecology Oncology. I understand that late payments may incur a charge of 5% interest, per month, until paid.

MEDICAL RECORD COPIES/DISABILITY FORM CHARGES

Disability form completion and copying of medical records incur a \$25.00 charge payable in advance of completion.

CHANGE OF ADDRESS AND/OR INSURANCE

I agree to notify Bay Area Gynecology Oncology of any changes to my address, phone number, employment, and, insurance. I have read all the above information on this sheet and have agreed that (regardless of my insurance) I will pay for all Medical Services provided by James Lilja MD, Katherine Volpe MD or any health care professional acting on their behalf. **As a courtesy**, our billing service will assist you in filling your insurance claim, within reasonable bounds. This office will expect prompt payment from your insurance company (usually within 30 days of the billing date). If this is not the case, we ask that you help us collect from your Insurance Carrier or settle your bill at the end of this time period.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN

I hereby authorize the release of any **Medical Information** necessary to process these claims, and I request payment of insurance benefits to: James Lilja, MD, Katherine Volpe, MD and/or Bay Area Gynecology Oncology. I agree that unpaid insurance balances are my full responsibility. I also authorize the release of any information acquired in the course of my examination or treatment to hospital, other physicians, and/or my insurance company. Ultimately, I am responsible for the balance of my account for any services and/or charges rendered.

CANCELLATION POLICY

I agree to appear **within 15 minutes of my appointment time**. I agree to notify the office if I must cancel an appointment **greater than 24 hours prior to my appointment**. If I fail to do so, I agree to pay the \$75.00 no show fee. Cancellation of a **surgery or an in-office procedure with less than 5 business days' notice** will incur an administrative charge up to \$500.00.

ELECTRONIC COMMUNICATIONS POLICY

I agree and consent to BAGO staff and BAGO agents using any and all electronic methods to contact me to coordinate my care, provide records and transmit patient statements. Consent includes BAGO's billing agent "Gentem" and BAGO's collections agent "TSI" sending communications via text and email.

AUTHORIZATION FOR HEALTH CARE MARKETING COMMUNICATIONS

Bay Area Gynecology Oncology (BAGO) values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. Certain types of promotional communications will not be sent to if you do not authorize BAGO to send them. BAGO will limit these to no more than four per year. You have a choice whether to receive these communications. Please initial if you do **not** authorize promotional communications from BAGO. I do **not** authorize _____