



**Roseburg Oncology, P.C.**  
R. Eugene Lienert, M.D.  
Randy L. Moore, D.O.  
Sylvia Gosline, M.D.

## **Patient Consent *for Evaluation, Treatment and Billing* Radiation Oncology and/or PET Imaging**

1. I grant permission for Community Cancer Center and/or Roseburg Oncology, M.D. P.C. (includes R. Eugene Lienert, M.D., Randy L. Moore, D.O. and Sylvia Gosline, M.D.) or their designate to **evaluate and/or treat** the above named patient.
2. **For Radiation Oncology patients:** The Community Cancer Center participates in Cancer Registry by providing your radiation treatment information to the facility where you were diagnosed. I authorize the Community Cancer Center and Roseburg Oncology, P.C. to disclose health and medical information for the purposes of Cancer Registry.
3. I authorize payment to be made to Community Cancer Center, Dr. Lienert, Dr. Moore and Dr. Gosline for services provided. I authorize Community Cancer Center to release to my insurance carrier and/or Health Care Financing Administration and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

**For PET Scan patients:** The Community Cancer Center provides the technical portion of the PET scan. You will receive a separate bill for the professional portion from the Radiologist who interprets your PET scan.

4. 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 ONCE THE PATIENT 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.
5. Authorization Period:       From \_\_\_\_\_ to \_\_\_\_\_  
    Lifetime or until notified

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

By: _____ (Patient or person authorized by law)	Date: _____
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