



Community Cancer Center

Roseburg Oncology, P.C.
Randy L. Moore, DO
Ashley W. Jensen, MD
Scott R. Moore, PA-C

Patient Name: _____

Patient Consent for evaluation, Treatment and Billing Radiation Oncology and/or PET Imaging

- I grant permission for Community Cancer Center and/or Roseburg Oncology, P.C. (includes Randy L. Moore, D.O., Ashley W. Jensen, M.D., Scott Moore, PA-C or their designate to evaluate and/or treat the above named patient.
- For Radiation Oncology patients:** The Community Cancer Center participates in Cancer Registry by providing you 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.
- I authorize payment to be made to Community Cancer Center, Dr. Moore, Dr. Jensen and Scott Moore, PA-C 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 and 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 you PET scan.

- 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.

- Authorization Period: From _____ to _____
 Lifetime or until notified

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

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient Representative)	Date: _____
Description of Representative's Authority: _____	