SURGICAL ONCOLOGY ASSOCIATES OF COLUMBUS

Consent to Medical Care and Treatment

I consent to all medical and surgical care, examinations and tests which are determined to be necessary for me, while I am a patient at this facility. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the result(s) of any treatment, procedure, or examinations to be performed on me while I am a patient at this facility. I understand that this facility is a teaching facility and I consent to allow medical students, interns, residents, fellows, nurses, and other health care personnel assisting and/or participating with my physician(s) in the performance of the diagnostic, medical and surgical procedures which may be performed upon me under my physicians' direction and supervision.

Release of Information

I authorize this facility to disclose copies of all or any part of my medical records obtained in the course of my diagnosis and treatment to any insurance carrier, workers compensation carrier, welfare agency or any other entity which may be providing financial assistance for my hospital, medical and/or nursing care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related conditions, psychiatric condition(s), and/or alcoholism or drug abuse. I also authorize the release of medical information for utilization and quality assurance review to my insurers or their subcontractors as required by any city, state, or federal laws.
I authorize this facility to disclose any medical information to my family physician, referring physician or any other provider directly involved in my medical care.

This consent is subject to written revocation by the patient or without revocation, will expire one year from this date.

Assignment of Insurance Benefits

I authorize payment of my insurance benefits directly to this facility. I understand that I am financially responsible for charges not covered by this authorization, and all bills not paid in a timely manner by my insurance carrier. This assignment also allows all physicians and groups providing care to me to bill and receive payment directly from my insurance carriers.
Statement to Permit Payment of Medical Benefits to Provider and Physician(s)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information need for this or a Medicare claim. I request that payment of authorized benefits be made on my behalf directly to this facility and to physicians and groups providing medical care to me.

Price Information

I understand that I am entitled to price information as stated in OHIO REVISED CODE SEC 3727.12.

Tobacco Free Information

Tobacco use of any kind is not allowed inside or outside of our facility. Compliance with our tobacco free policy is expected of all patients and visitors.

Privacy Notice

___ I have received a copy of SOAC's Notice of Privacy Practices.

___ I was offered a copy of SOAC's Notice of Privacy Practices, but refused.

Patient Signature Date

Patient's Representative (Patient Medically Unable to Sign) Date