Northwest CANCER CLINIC

HEALTH CARE AGREEMENT – FORM 1

This form contains facts you should know about your health care at Northwest Cancer Clinic (NWCC). If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name to show that you have read this form (or had it read to you) and agree to receive health care from us.

NWCC includes: (1) Northwest Cancer Clinic LLC Employees; (2) Northwest Cancer Associates PLLC Employees; (3) Subcontractors such as RJGJR PLLC. You understand that patient care is under the control of physicians who may be independent provider(s) and not an employee of the Clinic. Your physician may request other physicians or providers to provide services during treatment.

Radiation oncology services are provided by Northwest Cancer Clinic, LLC ("NWCC") All services which require a Washington State medical license are provided by the physicians of Northwest Cancer Associates PLLC and RJGJR, PLLC ("Physicians").

Your care team will consist of the radiation oncology physicians, the clinic's professionally trained staff, and may on occasion include physicians in training, medical and nursing students, and students interested in health care careers. They will work together to make recommendations about diagnosis and treatment. You will have an attending physician (who has primary responsibility for your care); but other physicians will be involved in your care.

You agree to permit a copy of this authorization to be used in place of the original.

The clinic is also interested in learning how to improve your care; and may have others contact you to check with you on how the physicians and clinic staff treated you. If you do not want to be contacted, please let the receptionist know so we can make sure we honor your wishes.

Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including radiation and/or surgery). These images may become part of your medical record.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive health care from NWCC. If there is any part of this form that is unclear, be sure to ask questions about it.

SIGNATURE (PATIENT AND/OR AUTHORIZED REPRESENTATIVE)	**PRINT NAME**	**DATE**

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner

☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 4. Sibling (brother, sister)

Signature of Translator (if applicable): _____

Northwest CANCER CLINIC

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT – FORM 2

The Notice of Privacy Practices describes how medical information about you may be used and disclosed, how you can get access to this information, and which procedures you may use if you have questions, concerns or complaints. This information will be used by Northwest Cancer Clinic (NWCC), Northwest Cancer Associates (NWCA) and/or RJGJR PLLC.

We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, and follow the information practices that are described in this notice. If want to ask questions today about this notice, please contact: NWCC Privacy Office **1-509-987-1800**. Please do not write comments on this form. Please ask for the "Joint Notice of Privacy Practices of NWCC and Certain Other Providers" brochure for instructions to make special requests about your Privacy Rights.

Note: We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice in writing by mailing your request to Privacy Officer, Northwest Cancer Clinic, 7379 W. Deschutes Ave, Suite 100, Kennewick, WA 99336.

You understand and acknowledge that healthcare and billing information obtained by the Clinic is shared with its independent healthcare practitioners and physicians. You authorize the Clinic and its independent healthcare practitioners and physicians to release healthcare and billing information to any relevant insurer or its agents, governmental program, or any other party potentially responsible for payment, authorization or evaluation of services rendered by the Clinic or independent practitioners and physicians. You expressly consent to the release of health care information relating to: (1) *alcohol and/or drug use,* (2) *psychiatric diagnosis and treatment, and* (3) *HIV, AIDS, sexually transmitted diseases and any related conditions.* You hereby release the Clinic and its independent healthcare practitioners and physicians from all legal responsibility or liability that may arise from disclosure of my health care information authorized by this Agreement. This release of information shall remain effective for the maximum period of time permitted by law.

By signing below, you agree that you have received the NWCC Practices.

SIGNATURE (PATIENT AND/OR AUTHORIZED REPRESENTATIVE)	**PRINT NAME**	**DATE**

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 4. Sibling (brother, sister)

Signature of Translator (if applicable): _____

For Emergency Situations, when we are unable to obtain acknowledgement but immediate treatment is needed for the following reason(s), we may elect to proceed without your signature. A :

Physician Signature	***Reason***	***Comments***
	Emergency Situation	
Physician Name		

Northwest CANCER CLINIC

PAYMENT AGREEMENT – FORM 3
NOTIFICATION OF COLLECTION FOR NWCC, NWCA AND/OR RJGJR PLLC on Patient's Behalf

I agree:

1. That I have been told that Northwest Cancer Clinic (NWCC), and the physicians of Northwest Cancer Associates PLLC (NWCA) and RJGJR PLLC (collectively, "Physicians") and other subcontractors involved in my care may share any financial information I provide to facilitate payment.
2. To assign to NWCC, NWCA, and/or RJGJR PLLC all insurance benefits payable for services provided.
3. To pay NWCC, NWCA, and/or RJGJR PLLC for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
4. To notify NWCC, NWCA, and/or RJGJR PLLC of changes to my insurance coverage and/or address.
5. That NWCC, NWCA, and/or RJGJR PLLC may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
6. To notify NWCC, NWCA, and/or RJGJR PLLC if I am not able to pay my balance due within 30 days of receipt.
7. If payment has not been received from the insurance carrier within 60 days, the entire bill will become my financial responsibility.
8. To apply to other financial programs that I may qualify for as requested by NWCC, NWCA, and/or RJGJR PLLC, should I be unable to pay my account.

I understand that:

1. When I receive treatments at NWCC, my insurance or me personally will be billed for both the technical (for the facility costs, i.e. building, equipment, supplies, staff time) and professional (for the costs of the professional services) portion of my treatment.
2. Each of these bills may incur a co-payment or co-insurance responsibility, depending on my insurance coverage. The exact amount of the co-insurance or co-payment will depend upon the actual services provided and the coverage provisions of any insurance I have.
3. NWCC requests my Social Security Number to verify my identity and to facilitate access to any potential federal health care benefits. Providing my Social Security number is voluntary.
4. Please read the following carefully and sign the bottom of this form prior to receiving services. By signing this form, you are agreeing to be responsible to both NWCC and Physicians for payment. If you have any questions, please ask our office staff.
5. I am responsible for payment for the services I receive at Northwest Cancer Clinic even if those services are provided by Physicians. My medical insurance is a contract between me and my insurance company. It is my responsibility to know my deductible and copayment amounts. The clinic billing staff will file claims with my insurer and do everything within reason to assist me with insurance billing, but ultimately I agree that I am responsible for any unpaid balance.

PAYMENT AGREEMENT – FORM 3 continued
NOTIFICATION OF COLLECTION FOR NWCC, NWCA AND/OR RJGJR PLLC on Patient's Behalf

OUR STATEMENT TO YOU: As a courtesy to you, and as is customary in the medical field, we may provide you with a combined statement for services received at Northwest Cancer Clinic for (i) technical services performed by and owed to NWCC and (ii) professional medical services provided by and owed to Physicians. NWCC is acting solely as your agent in collecting and remitting amounts owed to the Physicians. You are liable to Physicians for its fees. Upon request, we will provide you the allocation of fees between NWCC and Physicians. By signing below, you consent to paying NWCC for its services and for NWCC to pay Physicians on your behalf from the monies received from you and your insurer.

Statement to Permit Payment of Medicare Benefits to Provider
I request payment of authorized Medicare benefits for any services furnished to me by NWCC, NWCA, and/or RJGJR PLLC. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

- I acknowledge that I have read, understand and agree to these terms and conditions.
- I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
- **I agree that I have been informed that the bill I receive from NWCC will include charge(s) for NWCC, NWCA and/or RJGJR PLLC.**

SIGNATURE (PATIENT AND/OR AUTHORIZED REPRESENTATIVE)	**PRINT NAME**	**DATE**

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