



AGREEMENT REGARDING FINANCIAL RESPONSIBILITY and ASSIGNMENT OF INSURANCE BENEFITS: As a patient referred to Mary Bird Perkins Cancer Center for treatment, and having duly consented to such treatment, the undersigned acknowledges and accepts full financial responsibility for all charges and expenses incurred and for the payment thereof. If I have insurance that will cover all or part of these charges and expenses, I acknowledge and agree that my deductible, coinsurance and any portion of my account balance not covered by such insurance remains my responsibility and will be paid in full upon demand or in accordance with a payment schedule agreed upon by me and Mary Bird Perkins Cancer Center (herein referred to as MBPCC).

I hereby authorize and direct any insurance company or self-insured insurance program from which health insurance benefits may be due to pay directly to MBPCC all claims submitted by MBPCC to such insurer, and I hereby assign to MBPCC all such benefits or payments.

If I am eligible for Medicare benefits and Medicare should determine that certain charges and expenses incurred in connection with my treatment are not covered, I understand that it is my obligation to pay for all such charges.

If it should ever become necessary for MBPCC to refer this account to a collection agency or to an attorney-at-law for collection, I agree, whether I am a patient or a guarantor, to pay all interest, court costs and costs of collection incurred by MBPCC or such collection agency or attorney-at-law, including attorney's fees in an amount not to exceed twenty-five percent (25%) of the total amount of principal and interest which may be due and owing.

My signature herein below constitutes:

- 1. authority for MBPCC to inquire regarding my credit and my employment history and to answer questions about MBPCC's credit experience with me.**
- 2. that I am responsible for notifying MBPCC if my insurance changes, I am admitted to hospice or admitted to a nursing home during my course of treatment or while under the care of a MBPCC physician.**
- 3. as a guarantor, I unconditionally promise to pay to MBPCC any and all sums representing charges for services and/or supplies.**

AUTHORIZATION FOR HEALTHCARE RELATED CALLS, TEXTS, AND E-MAILS: I, the undersigned, hereby authorize and consent to Mary Bird Perkins Cancer Center(s), its employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide to the center(s). This consent and authorization will apply to the current appointment and any FUTURE appointments to Mary Bird Perkins Cancer Center(s). This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the clinic's address. If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R.S. 40:1299.53. Such third party's consent and authorization, however, is only valid for the period of my incapacitation.

YES NO

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I understand that my insurance company and/or their agents may need information necessary to make determination about payment/reimbursement. I hereby provide authorization to release to all insurance organizations, their successors, assignees, or other parties with whom they may have contracted, or others acting on their behalf and involved with payment for any charges payment/reimbursement, and/or quality review.

I hereby request and authorize you to furnish to **Mary Bird Perkins Cancer Center** any and all information you may have concerning me in connection with any illness, condition, or injury, including medical history, consultations, prescriptions, treatment, x-rays, and/or copies of any and all hospital or medical records which you may have pertaining to me.

YES NO

Do not release HIV information

Do not release Genetics information

CONSENT FOR RECEIVING INFORMATION: I consent to receive mailings, telephone or cell phone calls, and/or emails concerning appointments, screenings, services, events, fundraising or programs at or sponsored by Mary Bird Perkins Cancer Center.

YES NO

E-PRESCRIBING: I consent for Mary Bird Perkins Cancer Center to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes, and hereby provide informed consent to enroll me in the ePrescribe Program..

YES NO

CONSENT FOR PATIENT PHOTOGRAPHY: The use of clinical photography is routine to patient care and required by MBPCC for patient safety. I consent MBPCC to obtain my photograph for use in the electronic medical chart for identification purposes. I understand that once obtained, photographs become part of my legal health record and any disclosure is considered the release of protected health information and must follow all state and federal regulations. I understand that I have the right to refuse and such refusal may affect MBPCC's decision to provide services or treatment.

YES NO

POLICY ON ADVANCE DIRECTIVES: Federal law requires that we give you information about your right to make advance health care decisions, including the right to accept or refuse medical or surgical treatment. It is the policy of Mary Bird Perkins Cancer Center (MBPCC) to honor a patient's health care decision to the full extent required or allowed by law. You are not required to give advanced health care directives (a living will or durable power of attorney) in order to receive care at MBPCC.

I have executed an Advanced Directive: YES NO

If yes, Copy in Chart Copy with Patient Copy Requested

It is the policy of MBPCC that its employees, staff members, and physicians are not permitted to serve as witnesses to the patient's signature on any "advance directive" document (including "living wills", code orders, durable health care powers of attorney and the like) or the patient's signature on powers of attorney, last wills and testaments, or other legal documents. This policy does not prevent MBPCC employees from service as witnesses to the patient's

signature on documents required to be signed by patients (or the patient's representative) for consent to (or refusal to consent to) treatments at MBPCC.

ACKNOWLEDGMENT AND RECEIPT: CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS: I understand that as part of my healthcare, Mary Bird Perkins Cancer Center and its medical staff creates, receives and maintains health records describing my health history, symptoms, examination and test results include genetics testing/counseling, diagnoses, treatment and any plans for future care or treatment. I understand that my health information may be used and disclosed by this facility and its medical staff to carry out my care and treatment, to obtain payment and for this organization's health care operations.

I acknowledge that I have been provided with a copy of Mary Bird Perkins Cancer Center's *Notice of Health Information Privacy Practices* that provides a more complete description of information uses and disclosures, and I have had an opportunity to ask questions about anything I did not understand. I understand that I have the right to review the notice prior to signing this consent. I understand that the facility reserves the right to change its notice and practices. If it does so, and prior to implementation it will post/provide a copy of any revisions to the *Notice of Health Information Privacy Practices* or I may obtain a copy by contacting Mary Bird Perkins Cancer Center at (225-767-0847).

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Mary Bird Perkins Cancer Center is not required to agree to the restrictions requested: however, if it agrees, it is bound by our agreement.

I hereby consent to Mary Bird Perkins Cancer Center and its medical staff using and disclosing my health information for the purposes of my treatment, obtaining payment and for its health care operations.

This authorization is valid until revoked in writing by me.

Patient
Relationship to patient (if not signed by patient)

Date

Witness

Date

Acknowledgment refused: *

Efforts to obtain: *

Reasons for refusal: *