Steven W. Sukin, M.D **Miguel Mercado, M.D** **Penner Schraudenbach, M.D**
Abimbola Ayangbesan, M.D **Edward Sanchez Jr, M.D**

Tomball
506 Graham Dr. #150 Tomball, TX 77375
Phone: 281-351-5174 Fax: 281-351-5172

The Woodlands
17201 I-45S, MOB II, #305 The Woodlands, TX 77385
Phone: 281-351-5174 Fax: 281-351-5172

Willowbrook
13215 Dotson Rd. #170B Houston, TX 77070
Phone: 281-351-5174 Fax: 281-351-5172

Authorization Request for Medical Records

I hereby authorize use or disclosure of protected health information about me as described below

I _____ authorize **Dr. Sukin, Dr. Mercado, Dr. Schraudenbach, Dr. Sanchez, and/or Dr. Ayangbesan** to request any and all medical information from the following persons and or facilities.

Physician/Facility _____

Address: _____

Telephone: _____

Fax: _____

For the purpose of ☐ Continued Care ☐ Attorney/Legal ☐ Personal Use ☐ Insurance ☐ Other

Please release the following:

☐ Problem List
☐ Progress Notes
☐ History/Physical Exam
☐ Medication List
☐ Immunization Record
☐ List of all allergies
☐ X-Ray/Imaging Reports
☐ Laboratory Results
☐ EKG Reports
☐ Genetic Testing Information
☐ Other (Specify) _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Texas Urology Specialists. However, I understand that any action already taken in advance of this authorization cannot be reversed and revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____ _____
Signature of Individual Date of Signature Date of Birth

_____ _____ _____
Signature of Guardian (if applicable) Date of Signature Description of Guardian

Internal Use Only		
	Name	
	DOB	
	MRN	
	Text opt in: ☐ Yes ☐ No	PHI Update: ☐ Yes ☐ No

TEXAS ONCOLOGY

Patient Billing

"What our patients and families need to know."

Texas Oncology provides both quality medical and financial care to our patients. Patient confidentiality is maintained while receiving appropriate payment for the medical care provided. The following is a detailed summary of our policies and procedures regarding patient billing.

1. Patients will receive a cost estimate from a Business Office representative upon request if the insurance will not fully cover all services and/or the patient is underinsured or declared indigent.
2. Patients must pay co-pays at the time of service.
3. Primary, secondary, and tertiary insurance claims for services rendered will be filed by the Business Office.
4. After a payment is made by the insurance company, the Business Office will reconcile the explanation of payment. The patient will be billed for the unpaid amount unless a contract with an insurance carrier prohibits it.
5. Any claim denied due to patient ineligibility, benefit limits, or services not covered will be billed directly to the patient unless a contract with the insurance carrier prohibits it.
6. Patients should promptly notify the Business Office of any changes in insurance coverage, billing address, legal name, or referring physician.
7. Patients may request an alternative billing address.
8. Patient billing statements will be mailed out every 30 days with a return envelope.
9. Patients receiving treatment should inform the Business Office when admitted to a Skilled Nursing Facility.
10. A patient may request a patient statement of billed charges and payments at any time.
11. Patients may pay balances online using the Online Bill Pay portal at www.texasoncology.com.
12. All payments received will be electronically processed.
13. Texas Oncology does not charge interest for amounts past due; however, we reserve the right to submit any unpaid accounts over 120 days to an outside collection agency.
14. Any patient may receive text notifications, regarding their outstanding balance, to their mobile device. A patient may request to opt in or out of text notifications at any time by contacting their physician's Business Office. Message and data rates may apply.
15. Any patient balance over 45 days will receive a letter and/or phone call to either collect or to arrange a payment plan.
16. If a patient receives direct payment from an insurance company or a patient advocacy program, specifically indicated as payment for services rendered, Texas Oncology reserves the right to submit the balance due to an outside collection agency.
17. Any billing questions regarding oral medications are addressed by the pharmacist/pharmacy staff.
18. All Medicare beneficiaries are provided a copy of the Medicare Oncology Care Model Beneficiary Notification.
19. A patient may provide consent to release financial information in order to have others act on their behalf. Consent may be updated at any time by contacting their physician's Business Office.

Questions or complaints should be directed to the Texas Oncology Business Office at (281) 351 - 5174.

Patient Initials _____

Internal Use Only		
	Name	
	DOB	
	MRN	
	Text opt in: ☐ Yes ☐ No	PHI Update: ☐ Yes ☐ No

TEXAS ONCOLOGY

Financial Release of Information

As the patient, you are in control of the financial records pertaining to your medical care. We will not disclose financial information without your presence or advanced consent unless there is evidence of legal authority for another individual to act on your behalf. If you would like to provide advanced consent to disclose and discuss financial matters of your account with other individuals, please indicate in the fields below:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please note that staff will ask for key identifying elements that assist in establishing the proper individual. This may include the patient's legal name, date of birth, gender, address, telephone number, guarantor, subscriber, or other unique personal identifiers. To revoke consent at any time for any individual indicated above please contact our Business Office directly. You may be required to complete another Release of Financial Information form.

☐ I consent to the individuals listed above to have access to my financial record and act on my behalf.

☐ I consent to receive text notifications of my financial statements at _____ - _____ - _____

☐ I have reviewed a copy of the Patient Billing form (page 1) and accept the terms.

Please sign and provide date and time stamps below:

_____ _____
Patient Signature Date/Time

_____ _____
Responsible Party Signature Date/Time