Patient Consent & Financial Responsibility Agreement

Name: _____ Date of Birth: _____

At **Anchorage Radiation Oncology Center**, we truly appreciate the opportunity to provide you with compassionate, state-of-the-art care. This agreement identifies your financial obligations for all the services you receive from us, including the services provided today and in the future. Please let us know if you do not understand any of the items discussed in this agreement.

Responsibility of the Patient

1. You are financially responsible for any deductible or co-insurance amounts determined by your insurance. All co-payments and/or deductibles for our services are due within 90 days of service. At your request, a financial counselor can provide you with an estimate of your financial responsibility for your treatment. However, please understand that an estimate is not binding and that the actual cost may be different. We accept payment for daily co-pays via check or credit card.

2. Please inform us of ANY and ALL insurance coverage you possess, and of any recent changes. This is crucial for proper billing and to ensure insurance coverage for our services, when available. We need correct and current information on a timely basis. If your insurance coverage changes, please contact our office immediately at 907-562-2002.

3. We will submit a claim to all insurers provided to us at the initiation of care for all applicable services and care provided. We will send you a statement reflecting the amount due after final processing from your insurance. If your account becomes delinquent, you agree to pay us for any expenses incurred on your account, including reasonable attorneys' fees and collection costs.

Financial Agreement for Integrative Services

Your medical provider may refer you to Integrative Services, these services may include palliative care, naturopathic oncology, nutrition or dietician services, acupuncture, and/or massage therapy. We will make every effort to bill your insurance provider for these services; however, please note that coverage varies by plan, and not all insurance companies reimburse for these services. If your insurance does not cover the cost, you will be responsible for the balance at our cash pay rate, which is 25% of the Medicare rate.

Initial: _____

Financial Agreement for Telehealth Services

Changes to coverage of telehealth services may have affected your insurance coverage. We will work with your insurance provider on your behalf to obtain coverage for these services but cannot guarantee these services will be covered. Effective February 1st, 2026 all telehealth services offered that are not covered by insurance will be billed at our cash pay rate of 25% of the Medicare rate.

Initial: _____

Financial Agreement for Principal Illness Navigation (PIN) Services

I understand that my serious health condition may benefit from Principal Illness Navigation (PIN) services. These services include help with coordinating my care, accessing resources, and navigating the healthcare system in alignment with the treatment plan outlined by my provider. I understand that trained staff may provide these services under the supervision of my healthcare provider. I agree to receive PIN services, and I am aware that Medicare Part B cost-sharing may apply. I know I can withdraw my consent at any time.

Initial: _____

PLEASE NOTE:

1. We are Medicare providers and accept assignments from Medicare. However, there may be a balance due from you after Medicare pays. Medicare law prohibits us from waiving this balance.

2. Carrying an outstanding balance will not prevent you from receiving continued care. If you are unable to cover an outstanding balance you may be eligible to apply for our Charity Care program, which provides financial assistance based on your needs.

By signing below, I acknowledge that I have read, understood, and agree to the financial terms outlined above.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Relation to Patient