



Collierville 400 Market Blvd., Suite 115 | Collierville, TN 38017 | o. 901.853.6012 | f. 901.854.7630

### CONSENT FOR CARE

I hereby give my consent for treatment to Integrity Oncology

Signature \_\_\_\_\_  
Patient, Parent or Guardian Relationship Date

### AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to Integrity for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in an attempt to collect said balance.

Signature \_\_\_\_\_  
Patient, Parent or Guardian Relationship Date

### LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Integrity for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature \_\_\_\_\_  
Patient, Parent or Guardian Relationship Date

### AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize Integrity to leave a message regarding pending appointments at my residence \_\_\_\_ Yes \_\_\_\_ No. It is ok to leave a message with my employer \_\_\_\_ Yes \_\_\_\_ No. It is okay to leave a message with any of my family members listed below:

Family Member \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Member \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Member \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Member \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_  
Patient, Parent or Guardian Relationship Date

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations developed October, 2002.

Signature \_\_\_\_\_  
Patient, Parent or Guardian Relationship Date

Please initial that you have received a patient brochure and a copy of your rights and responsibilities.

\_\_\_\_\_  
Initials