

AUTHORIZATION FOR MEDICAL TREATMENT AT RADIATION ONCOLOGY OF
NORTHERN ILLINOIS

I, the undersigned, hereby authorize Dr. Khater and whomever he may designate as his assistants/consultants to administer throughout the course of my treatment such evaluations, consultations, test, therapeutic planning and therapeutic services as they deem necessary to treat my condition. I know that I have a a right to be advised by my physician about my condition, the risks and benefits of any treatment as well as any alternatives to that treatment. I have the right to ask questions and I also have the right to refuse.

Dr. Khater is not an employee of Radiation Oncology of Northern Illinois. He is an independent contracted physician who is permitted to use this facility for the care and treatment of his patients.

Initial

I hereby certify that no guarantee, whether implied or stated, has been made regarding the results of any treatment. I realize that medicine is an evolving science with new information being discovered daily, but there is still much that is not known.

Patient Signature: _____

Date: _____

Witness: _____

INSURANCE ASSIGNMENT, AUTHORIZATION FOR RELEASE OF INFORMATION,
FINANCIAL AGREEMENT

I assign directly to Radiation Oncology of Northern Illinois and any other physician who provides care or services, any or all benefits otherwise payable to me from my insurer(s). I authorize Radiation Oncology of Northern Illinois and any physician who provides care or services to release to my insurer(s) such information as may be necessary for completion of my claim.

I AGREE TO PAY RADIATION ONCOLOGY OF NORTHERN ILLINOIS IN ACCORDANCE WITH THEIR REGULAR RATES AND TERMS WHICH ARE ITS USUAL AND CUSTOMARY CHARGES, FOR SERVICES RENDERED TO THE PATIENT FOR THE PATIENT'S ENTIRE COURSE OF SERVICES AND/OR TREATMENTS. (2) I UNDERSTAND THAT PAYMENT IS FOR SEVICES RENDERED. (3) IF RADIATION

ONCOLOGY OF NORTHERN ILLINOIS TAKES ANY ADDITIONAL STEPS TO COLLECT THIS ACCOUNT, I WILL PAY ALL COSTS OF COLLECTION; COLLECTION COSTS INCLUDING COUR COST AND REASONABLE ATTORNEY FEES. (4) NO EXTENSION OF TIME PAYMENT SHALL RELEASE ME FROM THESE OBLIGATIONS.

DATE

PATIENT SIGNATURE (OR AUTHORIZED PERSON)