Vista ONCOLOGY
Comprehensive Care for Cancers & Blood Disorders
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ **DOB:**_____

Please check one of the following:

❑ **I give permission to the employees of Vista Oncology, a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation:_____ Phone: _____

Name: _____ Relation:_____ Phone: _____

Name: _____ Relation:_____ Phone: _____

Name: _____ Relation:_____ Phone: _____

Name: _____ Relation:_____ Phone: _____

Name: _____ Relation:_____ Phone: _____

❑ I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

Vista ONCOLOGY
Comprehensive Care for Cancers & Blood Disorders
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Vista Oncology, a division of American Oncology Partners, P.A. (VO/AOP), as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide VO/AOP with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that VO/AOP will bill your insurance plan or program for services provided by VO/AOP and you agree you are assigning your right to receive payment or benefits from such insurer or program to VO/AOP and you are authorizing payment to be made directly to VO/AOP.
- You agree you are responsible for payment to VO/AOP of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, VO/AOP will use your personal health information internally and will share such information with your insurance policy and certain business associates of VO/AOP in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- VO/AOP owns and operates AON Pharmacy, LLC, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your VO/AOP physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use AON Pharmacy, LLC and may have your prescriptions filled wherever you choose. However, if you select AON Pharmacy, LLC to fill VO/AOP-issued prescriptions, then this policy and all other VO/AOP patient financial responsibility policies will also apply to the items and services provided to you by AON Pharmacy, LLC.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by VO/AOP clinicians at VO/AOP's own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to VO/AOP that results in a surplus on your account (i.e., a credit balance), VO/AOP may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and VO/AOP may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, VO/AOP will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PATIENT FINANCIAL POLICIES. A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST.

Patient Name (Print) _____ Date _____

Patient or Guarantor (Signature) _____

For office use:

Name (Print) _____ Date _____

Vista Oncology/AOP Employee (Signature) _____

Vista ONCOLOGY
Comprehensive Care for Cancers & Blood Disorders
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Vista Oncology, a division of American Oncology Partners, P.A., (VO/AOP) Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any VO/AOP facility or by submitting a request in writing to the corporate office at Vista Oncology, a division of American Oncology Partners, P.A., Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting **AONcology.com/policies/VO_NPP.pdf**

Date:_____

_____	_____
Patient Name (Print)	DOB
_____	_____
Patient (Signature)	Date
_____	_____
Patient or Guarantor (Signature)	Date

Vista ONCOLOGY
Comprehensive Care for Cancers & Blood Disorders
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

By signing below, I authorize Vista Oncology, a division of American Oncology Partners, P.A., (VO/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized VO/AOP texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by VO/AOP under my cell phone plan.

I know that I am under no obligation to authorize VO/AOP to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP".

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

PLEASE MARK THE FOLLOWING:

- ❑ I consent to receiving information via text. I understand I can withdraw my consent at any time.
  Text Cell #_____
- ❑ I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

_____ _____
Patient Name (Print) Date

_____
Patient (Signature)