Treatment and Financial Agreement

Treatment: HUPTI accepts the patient named below for proton therapy treatment. The undersigned hereby consents to HUPTI providing and administering all services and supplies ordered by the patient's attending physicians, and to the performance of all proton therapy procedures they deem advisable. I acknowledge that all medical treatment involves some risks and that no guarantee can be given regarding the outcome.

Financial Responsibility: I assign any benefits that I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments, and verdicts against any liable third party to HUPTI for reimbursement for my medical treatment received by HUPTI. If I fail to pay my outstanding HUPTI balance, I understand that HUPTI will have a lien against any such settlement, judgment, or verdict equal to the full amount of any unpaid HUPTI bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay to HUPTI the full amount of any outstanding balance owed by me, the patient, to HUPTI for medical services rendered. I also understand and agree to pay a $30.00 fee for any returned checks.

I agree to pay all charges made by HUPTI and the medical providers at their current rate for services rendered and for supplies used in providing care and treatment to the patient. I understand that any prepayment is for estimated charges only and agree that the final bill may be different. Full payment is required at the time of service unless other arrangements are made. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If all charges are not paid when due, I agree to pay both the reasonable collection agency and/or attorney fees associated with recovering any outstanding balance, which shall be deemed incurred upon referral for collection, plus costs, and interest at the current rate applicable by Statute to Virginia Judgments. Moreover, I authorize HUPTI to apply any overpayment from another HUPTI medical bill to any other accounts owed by the patient to HUPTI because of any prior treatment.

I understand that I am the responsible party primarily liable for payment of the below named patient's account. It is my sole responsibility to comply in a timely manner with all requirements, and supply all information and documents necessary to obtain payment or benefits by any HMO or insurer, CHAMPUS, Medicare, Medicaid, State-Local Hospitalization, Worker's Compensation carrier, governmental agency or other third-party source of benefits/payments. HUPTI may submit claims to such payees as a courtesy only, and is not obligated to do so, unless by regulation or contract with the insurer or government agency. I understand that professional fees may be billed separately from the treatment services. I understand that while I am receiving medical treatment at HUPTI, I may receive a separate bill from a health care provider and/or laboratory other than a bill from HUPTI and agree to pay any outside bills received to the extent that they are not paid by my insurance.

Pre-Authorization Responsibility: I understand it is my sole responsibility to obtain all required pre-authorizations for treatment and to fully comply with all pre-authorization requirements as stated by my insurance company. If I elect to be treated without a referral from an authorized physician and/or authorization from my insurance company, it is my sole responsibility to pay that treatment physician.

Patient/Family Conduct: I agree to be respectful and courteous to the HUPTI physicians, all medical providers, staff and other patients and visitors. I understand the importance of honoring my scheduled visits. I agree to provide at least 24 hours' notice to HUPTI should I need to cancel or reschedule an appointment.

Personal Valuables: I understand that HUPTI will not be responsible for any loss, theft, or damage to any personal property of patients or visitors.

Treatment and Financial Agreement

Notice of Deemed Consent for Infectious Disease Testing: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immune-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Please fill out the below grid for your insurance coverage. If you have a tertiary insurance, please let the Patient Coordinator know at your consult.

Primary Insurance	Secondary Insurance
Insurance Company Name____________________	Insurance Company Name____________________
Policy Number: ____________________________	Policy Number: ____________________________
Group Number: ____________________________	Group Number: ____________________________
Responsible Party Name: ____________________	Responsible Party Name: ____________________
Date of Birth: ______________________________	Date of Birth: ______________________________
Relationship to Patient: ____________________	Relationship to Patient: ____________________

☐ **I have read and understand the Treatment and Financial Agreement and I agree to be bound by its terms.**

____ ____________________

Printed Patient Name/ Responsible Party (*if patient is under 18)* **Date of Birth**

____ ____________________

Signature of Patient/Responsible Party **Date**