



V A L L E Y
 RADIATION
 THERAPY
 C E N T E R

2490 S. WOODWORTH LOOP, SUITE 150
 PALMER, AK 99645
 PHONE (907) 745-2900



A N C H O R A G E
 RADIATION
 THERAPY
 C E N T E R

2841 DEBARR ROAD, SUITE 100
 ANCHORAGE, AK 99508
 (907) 276 - 2400

Date _____

PATIENT PAYMENT AGREEMENT

Patient Name _____ Date of Birth _____

I understand that I am responsible for my medical bill and accept responsibility for any charges not covered and paid by my insurance company or other third party resources.

- If my insurance company requires pre-certification/authorization for services, I understand that it is my responsibility to obtain that authorization prior to the scheduled appointment.
- By signing below, I authorize the release of my medical records to the insurance carrier as may be necessary to determine benefits and to process claims for health care services provided to the above named patient.
- I authorize assignment of Medicare/Medicaid, other federal/state agents or any commercial insurance carriers to pay benefits directly to the provider of service(s).
- This is a Lifetime insurance authorization granting the provider authority to file claims on my behalf.

In addition to the above patient payment agreement, I sign below acknowledging receipt of the office's NOTICE OF PRIVACY PRACTICES

Signature _____ Date _____

Witness _____ Date _____