

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I have presented myself to the The University of Kansas Cancer Center and/or affiliates (The University of Kansas Hospital, Professional Services of Kansas University, University of Kansas Physicians, Inc or Mid-America Cardiology) and hereby consent to the rendering of routine diagnostic procedures and routine medical treatment as the Attending Physician or other members of the Medical Staff or their designees consider being necessary and appropriate. I understand that The University of Kansas Cancer Center and/or affiliates is a teaching hospital and that under the supervision of my doctor, resident physicians and other learners may be observing or be assisting in my treatment or procedure and may assist in opening and closing, dissecting tissue, and/or removing tissue. I also understand that nurses and other health care workers will be caring for me during my treatment and procedure.

I realize that I have the right to refuse any drugs, treatment, or procedures, and I realize this refusal may represent a significant risk to my health and life.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as a result of examination, procedures, and/or treatments provided by The University of Kansas Cancer Center and/or its affiliates.

I hereby assign to The University of Kansas Cancer Center and/or its affiliates the medical expense benefits to which I am entitled and otherwise payable to me, not to exceed the organization's regular charges for this period of treatment. I further agree that if the amount is not enough to cover the entire expense rendered by the organization I will be responsible for the difference. I permit a copy of this authorization to be used in place of the original.

I authorize The University of Kansas Cancer Center and/or its affiliates to release to third-party payors pertinent medical information relating to my care that may be necessary for the completion of claims for payment.

This consent shall be in effect unless revoked, in writing, to the administrator and to the attending physician.

I acknowledge that I have been offered a copy of my rights as a patient, as well as information on formulating advance directives. _____(initials)

I DO _____ **I DO NOT** _____ have an advance directive at this time. (If I do have such a document, I am providing a copy for my medical record.)

Patient's Name – *please print*

Signature – *patient or person authorized to sign for the patient*

Relationship to the Patient

Witness to Authenticity of Signature

Date Signed Time