

**BAY AREA GYNECOLOGY ONCOLOGY**  
**JAMES LILJA, M.D.**  
**555 Knowles Dr St 203**  
**Los Gatos CA 95032**  
**PATIENT CONSENT/AGREEMENT FORM**

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. This may include the administration of needed anesthetics, the use of prescribed medication, the use of diagnostic procedures and the use of x-rays and laboratory test.

**RELEASE OF INFORMATION**

**I authorize the release of any medical information to and from any medical facilities, physicians, and/or my insurance company.**

**I also authorize the following persons to receive any of my medical information:**

\_\_\_\_\_

**PRIVACY POLICY ACKNOWLEDGEMENT**

I acknowledge that I have been given *The Notice of Privacy Practices* for the office of James Lilja, M.D.

**PAYMENT:** I understand that I am responsible for payment for services **including co-payments**, balances and charges for services not covered by insurance. All payments are due at the time of service. I authorize the payment of insurance benefits to James Lilja, M.D. I understand that **late** payments may incur a charge of 5% interest, per day, until paid.

**REFERRAL/AUTHORIZATIONS:** I agree to provide a referral or an authorization from my PCP-Primary Care Physician or referring physician if my insurance is an HMO at the time of my visit. If no referral form is provided, my visit may be re-scheduled.

**MEDICAL RECORD COPIES/DISABILITY FORM CHARGES:** Disability form completion and copying of medical records incur a \$25.00 charge and will not be completed without payment.

**CHANGE OF ADDRESS AND/OR INSURANCE:**

I agree to notify Dr. Lilja's office of any changes to my address, phone number, employment, and, insurance. I have read all the above information on this sheet and have agreed that (regardless of my insurance) I will pay for all Medical Services provided by James Lilja MD or any health care professional acting on their behalf. **As a courtesy**, our billing service will assist you in filling your insurance claim, within reasonable bounds. This office will expect prompt payment from your insurance company (usually within 30 days of the billing date). If this is not the case, we ask that you help us collect from your Insurance Carrier or settle your bill at the end of this time period.

**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:** I hereby authorize the release of any **Medical Information** necessary to process these claims, and I request payment of insurance benefits to: James Lilja, M.D. I agree that unpaid insurance balances are my full responsibility. I also authorize the release of any information acquired in the course of my examination or treatment to hospital, other physicians, and/or my insurance company. Ultimately I am responsible for the balance of my account for any services and/or charges rendered.

**LATE/NO SHOW FEES:** I agree to appear **within 15 min of my appointment time**. I agree to notify the office if I must cancel an appointment **greater than 24 hours prior to my appointment**. If I fail to do so, I agree to pay the Charges for a 15 min office evaluation (indexed to the current year).

**TRANSLATION SERVICES:** I also authorize the following person(s) to provide translation services if necessary:

\_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date