RUTGERS
Cancer Institute
of New Jersey

General *Consent* and Acknowledgement

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Patient Name: Date of Birth:

Consent for Treatment:

I request and give consent to receive healthcare services from the Rutgers Robert Wood Johnson Medical Group (RWJMG) as provided by the medical staff, faculty or their designees, and licensed nurses. I understand that the Robert Wood Johnson Medical Group is affiliated with the Robert Wood Johnson Medical School. As such, I have been advised and understand that some attending physicians, medical fellows, residents, and students who may provide my care and treatment are employed by the State of New Jersey-Rutgers University. I authorize and request that RWJMG and my clinician(s) perform assessments, administer treatments and medications, and obtain laboratory tests as they believe may be considered advisable in the diagnosis and treatment of my condition. I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment at RWJMG and that there are possible complications that may result from the course of treatment I choose which was explained to me, and I understand the risks versus benefits assessment. I hereby release any RWJMG clinician from responsibility for any injury or other adverse outcome that results from my leaving RWJMG services against clinical and medical advice. I acknowledge and understand that I have read this consent or have had it read to me in my preferred language, and agree that the information referred to in it has been discussed with me. I have been given an opportunity to ask further questions about any areas which were not clear to me and I am satisfied with the explanation and all of my questions have been answered.

Patient Rights, Responsibilities, and Notices:

I acknowledge that I have received a copy of the following:
Notice of Privacy Practices

❑ Yes ❑ Refused (Please Initial) ____

General Acknowledgements:

❑ RWJMG may leave a message on my/my family's voicemail confirming appointments and/or information requested by me regarding treatments or medications.

❑ RWJMG may not leave a message on my/my family's voicemail.

Cancellation of Appointments:

I agree that I will provide adequate notice to cancel a scheduled appointment.

Release of Information for Processing Benefits:

I hereby authorize RWJMG to release my diagnosis and necessary clinical records for the purpose of obtaining reimbursement/payment for treatment services provided directly to me or my dependents. Information may be released to any third-party payor having responsibility for payment of charges for treatment including review agents, auditors, managed care, and utilization review agents. This consent is valid until such time that all claims have been settled to the satisfaction of RWJMG or up to one year from the date of service from RWJMG, whichever is longer. I understand that in some cases, I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorized RWJMG to contact the actual or additional insured (eg. my spouse) and to share information necessary to obtain reimbursement for services. I understand that I am ultimately responsible for any and all charges not paid by medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

Assignment of Benefits:

In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to RWJMG all rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to RWJMG for charges not covered by this assignment.

I certify that I am the patient. If I am not the patient, I certify that I am duly authorized as the patient's general agent to execute the above and accept its terms. I acknowledge that a copy of this consent will be provided to me upon request.

Patient/Person Authorized to Consent:

_____
(Print Name)

Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____
(Print Name)

Signature: _____

Relationship to Patient: _____ Date: _____