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**Metro Chicago Surgical Oncology, LLC**

3201 Old Glenview Rd.

Wilmette, IL 60091

(847)512-1849 P

(847)512-1850 F

**Billing Authorization**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient Name) authorize Metro Chicago Surgical Oncology, L.L.C., MCSO Radiation Oncology, LLC., and any and all member physicians who provided services to you or on your behalf to bill third party payers including but not limited to Medicare, Medicaid and all private PPO/HMO insurances for services rendered on my behalf.

I understand that I am responsible for non-covered services, co-payments, deductibles, etc.

I further understand that all payments for non-covered services, co-payments, deductibles, etc. are due within (30) days from date of invoice. After thirty (30) days, late fees and finance charges may be assessed. In the event that this matter is referred to an outside collection source, I agree to be responsible for any and all costs incurred in the course of collecting any past due balance.

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Patient/Responsible Party Signature Date

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Mailing Address Apt # City Zip Code