Arizona Oncology Associates, P.C.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date:_____

Patient Name: _____ ( ) _____
Last *First* *M.I.* *Home Telephone*

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City *State* *Zip* *City* *State* *Zip*

DOB:_____ Age_____ ☐M ☐F SS# _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Check Marital Status*

Employer:_____ ( ) _____
Name *Telephone*

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

(Other than patient)

_____ _____ _____
Address State *Zip Code*

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone:( )

Insured Name: _____ DOB_____ Group #_____ Policy #_____

Secondary Ins: _____ Telephone:( )

Insured Name: _____ DOB_____ Group #_____ Policy #_____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Arizona Oncology Associates, P.C.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Arizona Oncology Associates, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.
4. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Arizona Oncology Associates, P.C.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from Arizona Oncology Associates, P.C.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (*circle one*)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: _____
MRN: _____ LOC: _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS
_____

Original - Medical Record Copy to - Patient or Personal Representative