ARIZONA ONCOLOGY

United in Healing with The US Oncology Network

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

Patient Name: ______________________________ ( ) ______________
Last First M.I. Home Telephone

Home Address: ______________________ Mailing Address: ______________________

City____________ State: ____ Zip Code: ______ City____________ State: ____ Zip Code: ______

Date of Birth: ____________ Age: ________ ☐ M ☐ F SS# ______________

Check Marital Status: Married Single Divorced Widowed Other

Employer: ______________________________ ( ) ______________
Name Telephone

______________________________ ______________
Address Occupation

Responsible Party: ______________ ______________ ( ) ______________
Name Relationship Telephone

(Other than patient) ______________ ______________ ______________
City State Zip Code

Referring Physician: ______________________ Primary Care: Physician: ______________________

Primary Ins: ______________________ Telephone: ( ) ______________

Insured Name: ______________ DOB: ________ Group #: ________ Policy #: ________

Secondary Ins: ______________________ Telephone: ( ) ______________

Insured Name: ______________ DOB: ________ Group #: ________ Policy #: ________

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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 the original.

______________________________ ______________
Patient Signature Date / Time AM or PM (circle one)

______________________________ ______________
Responsible Party Signature Relationship Date / Time AM or PM (circle one)

PHYSICIAN: ______________________ EMPLOYEE INITIALS

MRN: ____________ LOC: ____________ ____________

Original - Medical Record Copy - Patient or Personal Representative