

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Acct #: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ ( )  
Last First M.I. Home Telephone

Home Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
Street Street

DOB: \_\_\_\_\_ Age \_\_\_\_\_ M F SS# \_\_\_\_\_ Married Single Divorced Widowed Other  
City State Zip City State Zip Sex Check Marital Status

Employer: \_\_\_\_\_ ( )  
Name Telephone  
 \_\_\_\_\_  
Address Occupation

Responsible Party: \_\_\_\_\_ ( )  
Name Relationship Telephone

Emergency Contact: \_\_\_\_\_  
 Spouse/Next of Kin: \_\_\_\_\_ ( )  
Name Relationship Telephone

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Primary Ins: _____	Telephone: ( )
Insured Name: _____	DOB _____ Group # _____ Policy # _____
Employer: _____	Telephone: ( )
Secondary Ins: _____	Telephone: ( )
Insured Name: _____	DOB _____ Group # _____ Policy # _____
Employer: _____	Telephone: ( )

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 **Cancer Care Northwest**.
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 **Cancer Care Northwest**. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. 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 **Cancer Care Northwest**.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from **Cancer Care Northwest**.

**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

\_\_\_\_\_  
 Responsible Party Signature Relationship

EMPLOYEE INITIALS \_\_\_\_\_ DATE \_\_\_\_\_

ID Verified ID Type \_\_\_\_\_