Patient ID _____ Date _____

CancerCare NORTHWEST

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

First Name _____ Middle Name _____ Last Name _____ Preferred Name _____

Mailing Address _____ Home Address _____

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

Primary Phone _____ Work Phone _____ Alternate Phone _____ Email Address _____

Marital Status _____ Birthdate _____ Age _____ Sex _____ Social Security Number _____

Language _____ Race _____ Ethnicity: Hispanic, Non-Hispanic, or Other

Occupation _____ Employer _____ Employment Status _____

Emergency Contact _____ Relationship _____ Contact Phone _____

Referring Physician _____ Primary Care Physician _____

Primary Insurance Carrier _____ Insured ID _____ Policy Group _____

Insured Person _____ Insured DOB _____ Relationship to Insured _____

Secondary Insurance Carrier _____ Insured ID _____ Policy Group _____

Insured Person _____ Insured DOB _____ Relationship to Insured _____

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 my payments are made directly to me or my representative, I will endorse such payments to **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 statements is considered the same as original.

Patient Signature _____ Responsible Party Signature _____ Relationship _____

Employee Initials _____ Date _____ Approved by Pt Adv _____ Date _____