
Patient ID Date

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: Home Cell Alt Phone: Home Cell Work Phone Email Address

Marital Status Date of Birth Age Sex Social Security Number

Language Race Ethnicity: Hispanic Non-Hispanic Other

Occupation Employer Employment Status

Emergency Contact Relationship Contact Phone: Home Cell

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

Patient Signature Responsible Party Signature Relationship

FOR OFFICE USE ONLY

Employee Initials Date Approved by Pt Adv Date