ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: ________________ Cellular #:( ) ____________________

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

Home Address: ______________________________ Email: ____________________
Street
Preferred Method of Contact: ____________________

______________________________ Race: Preferred Language: ____________
City *State* *Zip*

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

Ethnicity: ☐Hispanic, Latino or Spanish Origin ☐Non Hispanic, Latino, or Spanish Origin

Employer: ____ ( ) ____________
Name *Telephone*

____ ____________
Address Occupation

Responsible Party: ____ ( ) ____________

Emergency Contact: Home # Cell#____________ Work#

Emergency Contact/ Spouse/Next of Kin: Home# Cell#____________ Work#

Referring Physician: ______________________ Primary Care Physician: ______________________

Referring Telephone: ( ) Primary Telephone: ( )

Primary Ins: ______________________________ Telephone:( ) ____________

Insured Name: ____________ DOB SS# Group# ________ Policy #____________

Insured's Empl ______________________________ Telephone:( ) ____________

Secondary Ins: ______________________________ Telephone:( ) ____________

Insured Name: ____________ DOB SS# Group#________ Policy #____________

Insured's Empl ______________________________ 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 Rocky Mountain Cancer Centers. I also authorize agents of any hospital, treatment center or previous physicians to furnish Rocky Mountain Cancer Centers copies of any records of my medical history, services or treatments.
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 Rocky Mountain Cancer Centers. 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 my representative, or me I will endorse such payments to Rocky Mountain Cancer Centers.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Rocky Mountain Cancer Centers.
5. I hereby authorize Rocky Mountain Cancer Centers to inquire into my credit history through a credit-reporting agency to verify the information I have provided and understand that this information will be used solely for the purpose intended and NOT released to any outside agency.

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: ______________________
ACCT NBR: ____________ LOC: ____________
FOR OFFICE USE ONLY

EMPLOYEE INITIALS ____________

Revision Date 11/3/2011