Front Range Cancer Specialists

Assignment of Benefits/Financial Responsibilities

Today's Date: ____/____/____

Patient Name: _____ ( )
Last First M.I. ( )
Home and Cell phone numbe

Home Address_____ Mailing Address:_____
Street Street

_____ _____
City State Zipcode City State Zipcode

DOB: ___/___/___ Age: ___ ( ) M ( )F SSN# _____-____-_____ ( ) Married ( ) Single ( ) Other
Sex ( ) Divorced ( ) Widowed
Marital Status

Employer:_____ ( )
Work Phone Numbe

Address: _____ _____
Occupation

Responsible Party: _____ _____ ( )
Name Relationship Phone Number

Emergency Contact: (Other than spouse)_____ _____ ( )
Relationship

Spouse/next to Kin:_____ ( )
Home and Cell phone number

Referring Physician: _____

Primary Care Physician: _____

Primary Insurance: _____ Phone: ( )

Insured Name: DOB / / Group# Policy#

Secondary Insurance: _____ Phone: ( )

Insured Name: _____ DOB / / Group# Policy#

1. I authorize my insurance carrier to release information regarding my coverage to Front Range Cancer Specialists. I also authorize agents of any hospital, treatment center or previous physicians to furnish Front Range Cancer Specialists copies of any records of my medical history,services or treatments. I also authorize the release of any medical information and/or reports related to any federal, state or accreditation agency, or any physician or insurance carrier as needed.

2. I understand that I am responsible for reasonable charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of collection and legal action (if required).

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 Front Range Cancer Specialists. 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 co 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 Front Range Cancer Specialists.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or other patient by name or address, unless otherwise permitted by law) may also by shared with interested third parties, as detailed in the Notice of Privacy Policies package.

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 ( ) PM

Responsible Party Signature Date/Time ( ) AM ( ) PM

Confidential