ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ Age_____ Sex: ☐Male ☐Female ☐Other

Patient Address: _____ City:_____ State: _____

Zip Code: _____ Email: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

SS# _____ Marital Status: _____ Employer _____

Address _____ Occupation _____

Emergency Contact:

(Spouse / Next of Kin) _____ Relationship _____ Telephone _____

Referring Physician _____ Primary Care Physician _____

Do you have insurance? ☐Yes ☐No

Primary Insurance: _____ Telephone: _____

Subscriber Name: _____ DOB: _____

Employer: _____ Group #: _____ Policy #: _____

Do you have Secondary Insurance ☐Yes ☐No

Secondary Insurance Subscriber Name: _____ Telephone: _____

Subscriber Employer: _____ DOB _____ Group #: _____ Policy #: _____

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 AVAM Cancer & Blood Specialists, LLC. I also authorize agents of any hospital, treatment center or previous physician to furnish AVAM Cancer & Blood Specialists, LLC. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within AVAM Cancer & Blood Specialists, LLC.
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 AVAM Cancer & Blood Specialists, LLC. 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 AVAM Cancer & Blood Specialists, LLC.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with AVAM Cancer & Blood Specialists.
5. I understand that AVAM Cancer & Blood Specialists may share my patient information with third party agencies to conduct its business such as third-party billers, care -coordinators and other non-clinical parties for patient care related or administrative activities.

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

_____ _____

Responsible Party Signature Date/Time AM or PM