Hematology & Oncology Associates of Alabama

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ ( ) _____
Last First M.I. Home Telephone

Home Address: _____ Mailing Address: _____
Street Street

_____ _____
City State Zip City State Zip

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

Employer: _____ ( ) _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone:( ) _____

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone:( ) _____

Insured Name: 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 *Hematology & Oncology Associates of Alabama, LLC* (HOAA). I also authorize agents of any hospital, treatment center or previous physicians to furnish HOAA 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 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 HOAA.
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 HOAA. 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 HOAA.
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 payors; (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 HOAA.

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 _____

CONFIDENTIAL