UPSTATE HEMATOLOGY ONCOLOGY (UHO)

A TOUCH OF HEALING

Assignment of Benefits/Financial Responsibilities

Patient Name: _____ Today's Date: _____

Last Name First Name M.I.

Home Address: _____ Mailing Address: _____

Street Street

_____ _____

City State Zip City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: _____ Age: ____ M or F: ____ SS#: _____ Married Single Divorced Widowed Other

Please Circle One of the Above

Employer: _____ Employer Phone: ( ) _____

Name

_____ Occupation: _____

Address

Responsible Party: _____ Relationship: _____ Phone: ( ) _____

Name

Emergency Contact/: _____ Relationship: _____ Phone: ( ) _____

Spouse/Next of Kin Name

Referring Physician: _____ Primary Care Physician: _____ Phone: ( ) _____

Primary Insurance: _____ Phone: ( ) _____

Insured Name: _____ D.O.B.: _____ Group #: _____ Policy #: _____

Secondary Insurance: _____ Phone: ( ) _____

Insured Name: _____ D.O.B.: _____ 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 UHO. I also authorize agents of any hospital, treatment center or previous physicians to furnish UHO 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 my records for purposes of internal audits, research and quality assurance reviews within UHO.
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 UHO. 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 UHO.
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 Care Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include sharing of patient 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 UHO.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from UHO.

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 items. A duplicate of the statement is considered the same as the original.

_____ _____

Patient Signature Date/Time AM or PM (circle one)

_____ _____

Responsible Party Relationship Date/Time AM or PM (circle one)

UHO Use Only: Physician: _____ Acct #: _____ Financial Counselor: _____ Date: _____