Missouri Cancer Associates

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

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

( ) _____ ( ) _____
Home Telephone *Cell phone*

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:
Must be outside of your home: _____ _____ ( ) _____
Name Relationship *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Missouri Cancer Associates Physician: _____ Your Email Address: _____

Primary Insurance: _____ Phone: (_____) _____

Insured Name: _____ DOB _____ Social Security # _____

Group # _____ Policy # _____

Secondary Insurance: _____ Phone: (_____) _____

Insured Name: _____ DOB _____ Social Security # _____

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 Missouri Cancer Associates.
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 Missouri Cancer Associates. 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 Missouri Cancer Associates.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Missouri Cancer Associates.

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*)

Release of Information

The Patient above also authorizes the disclosure of health and financial information to:

Spouse Children Parents Step Parents/Children Contracted Care Giver/Guardian

Name of Person(s): _____

Day phone number: _____

Please initial and date this section: _____ Date: _____