Ocala Oncology
FLORIDA CANCER AFFILIATES
The US Oncology Network
www.FloridaCancer.com

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Lady Lake, FL 32159
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ASSIGNMENT OF BENEFITS/ FINANCIAL RESPONSIBILITIES

Today's Date: _____

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

( ) _____
Cell

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City State Zip *City State Zip*

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

Email: _____ Race*: _____

Ethnicity* Hispanic/Latino: ☐Yes ☐No Preferred Language*: _____

Preferred Contact Method: ☐Cell Phone ☐Home Phone ☐Work Phone ☐Email ☐Home Address

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

* Not Required

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 _____