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Phone (239) 313-2740 • Fax (239) 313-2741
 11181 Health Park Blvd., Suite 3020 • Naples, FL 34110
Phone (239) 653-9118 • Fax (239) 653-9108

**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 #: _____

- 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).
- I authorize my insurance carrier to release information regarding my coverage to Florida Cancer Affiliates.
- 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.
- 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 _____