FLORIDA CANCER AFFILIATES

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Phone (352) 732-4032 • Fax (352) 732-4191
☐ 13940 US Hwy 441 N • Lady Lake, FL 32159
Phone (352) 259-8940 • Fax (352) 430-1073

ASSIGNMENT OF BENEFITS/ FINANCIAL RESONSIBILITIES

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

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