



Ocala
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Ocala, FL 34474
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Fax (352) 620-0419

Timber Ridge
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Ocala, FL 34481
Phone (352) 237-7170
Fax (352) 237-8808

Lady Lake
13940 US HWY 441 N
Lady Lake, FL 32159
Phone (352) 259-8940
Fax (352) 430-1073

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 _____