ALABAMA ONCOLOGY®

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

PATIENT INFORMATION

Date_____/_____/ ______

Last Name:______________________________ First Name:______________________________ Middle Name:______________________________ DOB:_____/_____/ ______

❑ Male
❑ Female Social Security Number ________________________________ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Ethnicity: ❑ Hispanic ❑ Not Hispanic ❑ Declined ❑ Unknown

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Nat Hawaiian/Pacific Islander ❑ Black or African American ❑ White ❑ Other

Address:____ City:_____________________________ State:___________ Zip:___________________

Primary Phone: ( )______________________ Secondary Phone: ( ) __________________ Email: ____

Emergency Contact Person:____ Relationship:__________________________ Phone: ( )_________________

Employer:________________________ Address:_______________________________ Occupation:__________________ Phone: ( )_________________

RESPONSIBLE PARTY

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE

First Name:_____________________________________ Middle Name:_____________________________________ Last Name:_____________________________________

Responsible Party Address:____ City:_____________________________ State:___________ Zip: _____________

Phone: ( )______________________ Soc. Sec. #:_________________________ Relationship: ________________________ DOB:_____/_____/ ______

LIVING ARRANGEMENT

❑ With Spouse ❑ Alone ❑ With Children ❑ With Relatives ❑ Care Facility/Nursing Home ❑ Other____

REFERRAL INFORMATION

Primary Care Physician:______________________________ Address:____ Phone: ( )_________________

Referring Physician: _________________________________ Address:____ Phone: ( )_________________

INSURANCE INFORMATION

Primary Insurance:____ Contract #:____

Secondary Insurance:____ Contract #: ____

Part D/Medication Drug Coverage:____ Contract #:____

If the name on the insurance card is not the patient, complete the section below

Insured Name:________________________ Address:__________________________________ City:_____________________ State:_________ Zip:_______________

Phone: ( ) _____________________ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other Birthdate:_____/_____/ ______

Employer:____ Insured Social Security #: ___________________________ Effective Date of Insurance: ___________________________

I accept full responsibility for all charges for services rendered by Alabama Oncology (ALONC). I authorize my insurance carrier to release information regarding my coverage to ALONC. I assign all benefits and authorize payment directly to Alabama Oncology of any medical or government benefits due from my insurance, health plans, and/or government programs. I agree, in the event of non-payment or underpayment, to assume the costs of the difference, interest, collection, and/or legal action (if required). In the event that my insurance carrier does not accept this Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to ALONC.

I authorize the release of any medical information and/or reports necessary for review, treatment, payment, and health care operations. I understand that this includes but is not limited to administrative, financial, legal, research, internal audits, federal, state, accreditation, and quality improvement activities conducted by or for my health care provider(s) and health plans, that are essential to support treatment, payment, and health care operations.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.
INSURANCE IS FILED AS A COURTESY. CO-PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE - THANK YOU.

____ ____

Patient's or Authorized Representative's Signature Date