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DBA Comprehensive Cancer Centers of Nevada (CCCN)

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name: _____ () _____
Last First MI. Home Telephone

Home Address: _____ () _____
Street Cell Telephone

City State Zip Date of Birth: _____

M F Sex Social Security # _____ Married Single Divorced Widowed Other
Check Marital Status

Patient's Employer(s): _____ () _____
Name Telephone

Address Occupation

Insured's Employer: _____ () _____
Name Relationship Telephone

Contact:

Spouse/Next of Kin: _____ () _____
Name Relationship Telephone

Other Contact not living with you: _____
Name Relationship Phone#

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: () _____

Policy Holder Name: _____ DOB _____ Group # _____ Policy# _____

Secondary Ins: _____ Telephone: () _____

Policy Holder Name: _____ DOB _____ Group # _____ Policy# _____

- Initial 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).
- Initial 2. I authorize my insurance carrier to release information regarding my coverage to CCCN. I also authorize agents of any hospital, treatment center or previous physicians to furnish CCCN copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within CCCN
- Initial 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 CCCN. 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 CCCN.
- Initial 4. I understand that I have a right to request and receive a Notice of Privacy Practices from Comprehensive Cancer Centers of Nevada.

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)

EMPLOYEE INITIALS