

# Sacramento Center for Hematology and Medical Oncology Inc.

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ ( ) \_\_\_\_\_  
Last First M.I. Home Telephone

Home Address: \_\_\_\_\_ Street \_\_\_\_\_ Mailing Address: \_\_\_\_\_ Street \_\_\_\_\_

DOB: \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F SS# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
City State Zip City State Zip  
 Married  Single  Divorced  Widowed  Other  
Check Marital Status

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 Sacramento Center for Hematology and Medical Oncology Inc. (SCHMO).
- 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 SCHMO. 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 SCHMO.
- I understand that I have a right to request and receive a Notice of Privacy Practices from SCHMO.

**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 \_\_\_\_\_