

# Fairfax-Northern Virginia Hematology-Oncology, P.C.

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

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

Patient Name: \_\_\_\_\_ ( ) \_\_\_\_\_  
LastFirstM.I.Home Telephone

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

DOB: \_\_\_\_\_ Age \_\_\_\_\_  M  F SS# \_\_\_\_\_  Married  Single  Divorced  Widowed  Other  
SexCheck Marital Status

Employer: \_\_\_\_\_ ( ) \_\_\_\_\_  
NameTelephone  
 \_\_\_\_\_  
AddressOccupation

Responsible Party: \_\_\_\_\_ ( ) \_\_\_\_\_  
NameRelationshipTelephone

Emergency Contact:  
 Spouse/Next of Kin: \_\_\_\_\_ ( ) \_\_\_\_\_  
NameRelationshipTelephone

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 Fairfax-Northern Virginia Hematology-Oncology, P.C. (FNVHO). I also authorize agents of any hospital, treatment center or previous physicians to furnish FNVHO 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 FNVHO.
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 FNVHO. 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 FNVHO.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

**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: _____ <p style="text-align: center; font-size: small;">FOR OFFICE USE ONLY</p>	EMPLOYEE INITIALS _____
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