

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Legal Name _____
Last First M.I. Acct. No.

Preferred Name _____

Home Address _____ Mailing Address _____
Street Street

City State Zip City State Zip

() Home Phone () Cell Phone Email

DOB _____ Age _____ M F Intersex Other Married Single Divorced Widowed Domestic Partner Other
Sex Assigned at Birth Check Marital Status

Emergency Contact _____ () _____
Name Relationship Phone

Referring Physician _____ Primary Care Physician _____

Primary Insurance _____ Co-pay _____ () _____
Phone

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

Secondary Insurance _____ Co-pay _____ () _____
Phone

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

Tertiary Insurance _____ Co-pay _____ () _____
Phone

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

I acknowledge that New York Oncology Hematology, PC ("NYOH") is providing care and treatment to me and I agree to pay charges for such care and treatment. I understand that insurance benefits are subject to verification and I am responsible for any charges not covered by insurance in accordance with the policies, rates and terms established by NYOH.

I hereby assign to NYOH any insurance or other third-party benefits available for health care services provided to me. This includes an express assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims, including the right to bring suit against any such insurance company, health care benefit plan, employee benefit plan, or plan administrator in my name with derivative standing. In the event my insurance carrier does not accept Assignment of Benefits or if payments are made directly to me, I will forward NYOH all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I understand that NYOH has the right to refuse or accept assignment of such benefits.

The health plans NYOH participates in and a list of hospitals NYOH is affiliated with is available at www.newyorkoncology.com. If NYOH does not participate with your health plan, the amount or estimated amount that NYOH will bill you for health care services anticipated to be provided absent unforeseen medical circumstances is available upon request or upon the scheduling of an item or service.

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.

X _____
Signature Patient / Legal Representative* Print Legal Name

Relationship to Patient _____ Date _____ Patient's Name (if someone else signs)* _____

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

FOR OFFICE USE ONLY
PHYSICIAN _____
 YES NO 2 FORMS OF IDENTITY VERIFIED
LOC _____