NYOH New York Oncology Hematology

Assignment of Benefits/ Financial Responsibilities

Full Legal Name _____ **Preferred Name** _____

Home Address _____

Mailing Address _____

Home Phone _____ **Cell Phone** _____ **Email** _____

DOB _____ **Age** _____ **Sex Assigned at Birth** ☐ Male ☐ Female ☐ Intersex ☐ Other

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Other

Emergency Contact _____ **Relationship** _____ **Phone** _____

Referring Physician _____ **Primary Care Physician** _____

INSURANCE INFORMATION

Primary _____ Phone _____ Policy # _____

Group # _____ Copay _____ Policy Holder _____ DOB _____

Secondary _____ Phone _____ Policy # _____

Group # _____ Copay _____ Policy Holder _____ DOB _____

Tertiary _____ Phone _____ Policy # _____

Group # _____ Copay _____ Policy Holder _____ DOB _____

I acknowledge that New York Oncology Hematology, PC ("NYOH") is providing care and treatment to me and I agree to pay charges for such card 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 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.

_____ _____ _____

Signature Patient / Legal Representative* **Print Name** **Date**

_____ _____

Relationship to Patient **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 _____ **Location** _____

Account # _____ **2 forms of ID Verified** ☐ yes ☐ no **Employee Initial** _____