NYOH New York Oncology Hematology

www.newyorkoncology.com

Today's Date_____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name_____ _____
Last First M.I. Acct. No.

Home Address_____ Mailing Address _____
Street Street

_____ _____
City State Zip City State Zip

( ) _____ ( ) _____
Home Phone Cell Phone

DOB_____ Age_____ ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other
Sex Check Marital Status

Emergency Contact
Spouse/Next of Kin_____ _____ ( )_____
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.

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 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 if 18 or is otherwise incompetent to sign.

FOR OFFICE USE ONLY

PHYSICIAN_____

❑ YES ❑ NO 2 FORMS OF IDENTITY VERIFIED LOC_____