

# Northwest Cancer Specialists/ Northwest PET Imaging

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

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

Patient Name: \_\_\_\_\_  

Last
First
M.I.
Home Telephone
Cell Phone

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

Street
Street

City State Zip City State Zip

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

Sex
Check Marital Status

SNF \_\_\_\_\_ Telephone \_\_\_\_\_  

Nursing facility name
Telephone

Address

Employer: \_\_\_\_\_ Telephone \_\_\_\_\_  

Name
Telephone

Address Occupation

Responsible Party: \_\_\_\_\_ Telephone \_\_\_\_\_  

Name
Relationship
Telephone

Emergency Contact: \_\_\_\_\_ Telephone \_\_\_\_\_  
 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 # \_\_\_\_\_

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 Northwest Cancer Specialists/Northwest PET Imaging.
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 Northwest Cancer Specialists/Northwest PET Imaging. 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 Northwest Cancer Specialists/Northwest PET Imaging.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Northwest Cancer Specialists/Northwest PET Imaging.
5. The information provided may be verified using credit report information provided by Trans Union, LLC.

**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 \_\_\_\_\_ EMPLOYEE INITIALS \_\_\_\_\_

ACCT NBR: \_\_\_\_\_ LOC: \_\_\_\_\_

FOR OFFICE USE ONLY