Please fill out completely:

Ironwood Physicians DBA Ironwood Cancer & Research Ctrs; Ironwood Radiology

ASSIGNMENT OF BENEFITS / FINANCIAL POLICY

Patient Name: _____

Last *First* *M.I.* *Home Telephone*

House Address: _____

Is Arizona your permanent resident?

City *State* *Zip*

Date of Birth *Age* *Sex* *Social Security Number* *Marital Status*

Employer: _____

Name *Telephone*

Are you currently working? Yes or No **Retired? Yes or No** **Disabled? Yes or No**

Responsible Party: _____

Name *Relationship* *Telephone*

(Other than patient)

Address *State* *Zip Code*

Who referred you to us? Referring Physician: Primary Care Physician: Phone:

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 insurances. I will inform the billing dept of any change in insurance coverage. I understand that I may be responsible for charges if correct insurance is not provided and billed timely. 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 Ironwood Cancer & Research Centers billing dept.
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 Ironwood Cancer & Research Centers. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.
4. 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 Ironwood Cancer & Research Centers. I understand that Ironwood Cancer & Research Ctrs will collect any coinsurance amounts that I owe at time of service. This assignment will remain valid until revoked by me in writing.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Centers.
6. I authorize my insurance carrier to release information regarding my coverage to Ironwood Cancer & Research Centers.

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/Responsible Party : _____ **Date:** _____