TEXAS ONCOLOGY

Assignment of Benefits and Financial Responsibilities

Patient Name: _____ (Last / First / M.I.) _____ (Date of Birth) _____ (Age)

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Home Address: _____ (Street / City / State / Zip Code)

Mailing Address: _____ (Street / City / State / Zip Code)

Email Address: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Health / Hospice (Name): _____

The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Indian/Pakistani/Sri Lankan ☐ Chamorran ☐ Chinese ☐ Fiji Islander ☐ Filipino ☐ Guananian NOS ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Kampuchean/Cambodian ☐ Korean ☐ Laotian ☐ Melanesian NOS ☐ Micronesian NOS ☐ Native American ☐ New Guinean ☐ Other Asian including Asian NOS and Oriental NOS ☐ Pacific Islander NOS ☐ Polynesian NOS ☐ Samoan ☐ Tahitian ☐ Thai ☐ Tongan ☐ Vietnamese ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Sign Language ☐ Need an interpreter

Employer: _____ (Name / Address / City / State / Zip)

Responsible Party: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Emergency Contact

Spouse/Next of Kin: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Alternate Emergency Contact: _____ (Name) _____ (Relationship) ( ) _____ (Telephone)

Referring Physician: Primary Care Physician:

Primary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: Group Number:

Secondary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: Group Number:

Tertiary Insurance: _____ Telephone: ( ) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: Group Number:

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 Texas Oncology P.A.
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 Texas Oncology P.A. 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 Texas Oncology P.A.
4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.
5. I understand the Texas Oncology patient portal (My Care Plus) will use my email address to send me information about accessing my patient information online.

Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

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.

_____ _____

Please return completed form to the appropriate physician's office.

Patient Signature | Date/Time AM or PM (*circle one*)

Responsible Party Signature | Relationship | Date/Time AM or PM (*circle one*)

PHYSICIAN:	ACCT #	LOC:	EMPLOYEE INITIALS:

Please return completed form to the appropriate physician's office.