



ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Date: _____

Patient Name: _____ () _____ ()
Last First M.I. Home# Cell#

Home Addr: _____ Mailing Addr: _____
Street Street

DOB: _____ Age _____ M F SS# _____ Married Single Divorced Widowed

Employer: _____ () _____
Name Telephone

Emergency Contact _____
Spouse/Next of Kin: _____
Address Occupation

Name Relationship Home Phone: _____
Work Phone: _____

Other Emergency Contact _____
Not in Household: _____
Name Relationship Home Phone: _____
Work Phone: _____

List family members other than above (full names) to whom we may speak regarding your medical condition:

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ () _____
Telephone

Insured Name: _____ DOB _____ SSN# _____ Group# _____ Policy# _____

Secondary Insurance: _____ () _____
Telephone

Insured Name: _____ DOB _____ SSN# _____ Group# _____ Policy# _____

1. I understand that it is my responsibility to provide Integrated Community Oncology Network, LLC ("ICON") with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **ICON** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **ICON** immediately upon any change in my insurance.

I further understand that in consideration of the services provided, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **ICON** which are not covered or reimbursed by my insurance I am responsible for any applicable deductible or co-payments prior to the provision of services. **ICON** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form for non-covered services. Should my account be referred to a collection agency or attorney for collection, I agree to pay all costs of collection, including interest and attorney's fees and costs.

2. I authorize my insurance carrier to release information regarding my coverage to Integrated Community Oncology Network, LLC (ICON). I also authorize agents of any hospital, treatment center or previous physicians to furnish ICON copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within ICON.

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 ICON. 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 ICON.

4. Please refer to ICON's HIPAA Privacy Notice to review how your health care information is used and disclosed.

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 _____

Responsible Party Signature _____ Relationship _____ Date/Time _____

Physician: _____
Acc't # _____ Loc: _____
FOR OFFICE USE ONLY

CONFIDENTIAL

Medical Records: White Copy / Business Office Medical Record: Yellow Copy / Patient: Pink Copy

EMPLOYEE INITIALS _____