compass oncology

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Legal Name: _____ **Preferred Name:** _____ **DOB:** _____
Last *First* *M.I.*

Home Phone: _____ **Cell Phone:** _____ **SSN#:** _____

Home Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Email Address: _____ **Preferred Contact Method:** ☐Cell Phone ☐Home Phone ☐Email

Sex at Birth: ☐M ☐F **Gender Identity:** _____ **Personal Pronouns:** _____

Sexual Orientation: ☐Straight or Heterosexual ☐Lesbian, Gay, Homosexual ☐Bisexual ☐Other: _____
☐Choose Not to Disclose

Marital Status: ☐Divorced ☐Domestic Partner ☐Married ☐Separated ☐Single ☐Widowed ☐Unspecified

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Decline to Specify

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐ Hawaiian/Other Pacific Islander
☐White ☐ Other: _____ ☐ Decline to specify **Preferred Language:** _____

Employment Status: ☐Employed ☐Full-time Student ☐Part-time Student ☐Retired ☐Unemployed ☐Unspecified

Employer Name: _____ **Employer Address:** _____

Responsible Party: _____ _____
Name *Relationship* *Telephone*

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

Referring Physician: _____ **Primary Care Physician:** _____

Primary Insurance: _____ **Telephone:** _____

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

Secondary Insurance: _____ **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 Compass Oncology.
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 Compass Oncology. 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 Compass Oncology.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Compass Oncology.

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 the original.

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

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

Employee Initials: _____