

HEMATOLOGY/ONCOLOGY ASSOCIATES OF HOUSTON, P.A.

PATIENT AUTHORIZATION/FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____

INSURANCE COVERAGE

_____ I certify that I have no insurance which will pay benefits for medical services to _____ hereafter referred to as "The Provider."

_____ I certify that this Insurance reported to Hematology/Oncology Associates of Houston, P.A. hereafter referred to as "The Provider", for medical services is a complete listing. I understand the Provider will not extend credit on or submit a claim for any insurance not reported on initial visit.

Insurance Assignment

In consideration of services rendered or to be rendered, I hereby assign and transfer to the Provider any benefits payable to or for my benefits under hospitalization or sickness insurance, and any other insurance coverage, to include major medical for the payment of such services rendered, I agree to cooperate, aid and assist the provider in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance may require for payment. This assignment extends to the total amount owned to the Provider

Medicare Patients

If a Medicare patient: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made in my behalf.

Release of Information

I understand that regardless of my assigned insurance benefit, I am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the Provider. I further understand that if my insurance benefits are paid directly to me from my insurance company for services that I have received from the Provider. I will reimburse the Provider the full amount of these services within fourteen days. I agree should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit. I as the designated responsible party, shall pay the reasonable attorney fees and/or collection expenses.

Release of Information

I authorize the Provider to release any medical information requested by representatives of local state or federal agencies, insurance companies, or other organizations, entities as may be required by said representatives for payment of claims arising out of these medical services that are due to the Provider.

Signature of Patient or Responsible Party

Date