Advanced
Oncology
Center, Inc.

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

2707 East Valley Blvd. Suite 109
West Covina, CA 91792
Ph: (626) 956-8009
Fax: (626) 956-8010

Today's Date:

Patient Salutation:	Home Telephone:
Patient Name:	Alternate/ Cell:
DOB: Age**:**	Email:
Address:	Gender:
City: State:	Marital Status:
Zip Code:	SS#:
Employer**:**	Occupation:
Address:	
City: State**:**	Emergency Contact:
Zip Code:	Relationship:
Tel:	Telephone **:**
EXT:	
Primary Insurance:	Secondary Insurance:
Insured Name:	Insured Name:
Subscriber #:	Subscriber #:
Group #:	Group #:
Employer : (if different from patient) Telephone #:	Employer : (if different from patient) Telephone #:

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 Advanced Radiation Oncology Medical Group, Inc. d/b/a Advanced Oncology Center, Inc. I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatment to Advanced Oncology Center, Inc. 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 and quality assurance reviews with within Advanced Radiation Oncology Medical Group, Inc. d/b/ Advanced Oncology, Inc.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing services including major medical benefits are herby assigned to Advanced Radiation Oncology Medical Group d/b/a Advanced Oncology Center Inc. This agreement 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 Advanced Radiation Oncology Medical Group, Inc. d/b/a Advanced Oncology Center.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers, (b) companies that produce chemotherapy and other drugs, (c) governmental bodies (such as Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant serviced may include the sharing of patient identifying information such as my name and address) and universities;(e) representative s and agents of my health benefit plan, (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with Advanced Radiation Oncology medical Group, Inc. d/b/a Advanced Oncology Center, Inc.

THIS AGREEMENT / CONSENT WILL REMAIN IN EFECT UNLESS REVOKED BY ME IN WRITING

Patient Signature: _____ **Date/Time:**_____

Responsible Party Signature: _____ **Date/Time:** _____