

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED, AND AUTHORIZE AND DIRECT MY INSURANCE CARRIER(S), INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH/MEDICAL PLAN TO ISSUE PAYMENT DIRECTLY TO NORTH SHORE ONCOLOGY-HEMATOLOGY ASSOCIATES, LTD FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR A FEE SHOULD I MISS AN APPOINTMENT WITHOUT RESCHEDULING IN ADVANCE. THIS FEE IS THE SOLE RESPONSIBILITY OF THE PATIENT.

FINANCIAL RESPONSIBILITY

WE WILL SUBMIT YOUR CLAIM TO YOUR INSURANCE COMPANY. HOWEVER, SHOULD YOUR INSURANCE COMPANY CONSIDER ANY OF THE SERVICES PROVIDED AS “NON-COVERED”, AND/OR SHOULD YOUR INSURANCE COMPANY NOT PAY US, FOR SERVICES PROVIDED TO YOU, WITHIN THIRTY (30) DAYS OF SUBMISSION OF A PROPERLY FILED “CLEAN” CLAIM, YOU WILL ACCEPT FULL FINANCIAL RESPONSIBILITY FOR PAYMENT OF THE BALANCE OF YOUR ACCOUNT.

IF YOUR INSURANCE COMPANY REQUIRES THAT WE COLLECT A CO-PAYMENT FOR SERVICES RENDERED AT OUR FACILITY, YOU ARE RESPONSIBLE FOR PAYING THAT CO-PAYMENT UPON ARRIVAL TO OUR FACILITY ON THE DATE OF SERVICE. ANY CO-PAYMENT NOT COLLECTED ON THE DATE OF SERVICE WILL BE SUBJECT TO AN AUTOMATIC SERVICE CHARGE ON YOUR NEXT STATEMENT.

UNPAID BALANCES ARE CONSIDERED DELINQUENT AFTER 60 DAYS. IT IS YOUR RESPONSIBILITY TO CONTACT OUR PATIENT ACCOUNTS DEPARTMENT IF FINANCIAL PROBLEMS ARISE. ANY OUTSTANDING BALANCE OVER 60 DAYS IS SUBJECT TO COLLECTION ACTIVITIES. ALL CHARGES INCURRED DUE TO COLLECTION ACTIVITIES ARE THE FULL RESPONSIBILITY OF THE PATIENT AND WILL BE ADDED TO THE OUTSTANDING BALANCE.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE

DATE