Cancer Center of Kansas

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☐ Chanute
☐ DCRO
☐ Dodge City
☐ El Dorado
☐ Fort Scott
☐ Independence
☐ Kingman
☐ Liberal
☐ MAT
☐ Manhattan
☐ McPherson
☐ Mowery
☐ Newton
☐ Parsons
☐ Pratt
☐ Salina
☐ Wellington
☐ Wichita 818
☐ Winfield

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (4)

Patient's Name:_____ Phone (H)_____ (C)_____

Home Address: _____ Mailing Address: _____

_____ _____
CITY STATE ZIP CITY STATE ZIP

Birthdate: _____/_____/_____ Age: _____ M F Social Sec. #: _____ Marital Status: M W S D O
MO DA YR SEX (CIRCLE ONE)

Employer: _____ Phone: (_____) _____
NAME OCCUPATION

Spouse: _____ Phone: (_____) _____
NAME / OCCUPATION / D.O.B.

Responsible Party: _____ Phone: (_____) _____
NAME RELATIONSHIP

Emergency Contact: _____ Phone: (_____) _____
(Outside Your Home) NAME RELATIONSHIP

Referring Physician: _____ _____
NAME CITY

Primary Care / Family Physician: _____ _____
NAME CITY

Primary Insurance: _____ Phone: ( )_____

Insured:_____ Policy #: _____ Group #:_____

Secondary Insurance: _____ Phone: ( )_____

Insured:_____ Policy #: _____ Group #:_____

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 Cancer Center of Kansas, P.A. (CCK). I also authorize agent of any hospital, treatment center or previous physicians to furnish CCK 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 the patient or designated patient representative(s), 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 CCK.**
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 CCK. 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 CCK.**
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 including (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the Food and Drug Administration and the Centers for Medicare and Medicaid Services); (c) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (d) representatives and agents of my health benefit program; (e) persons conducting quality or peer review or patient satisfaction surveys; (f) other clinical and non-clinical parties that have a contractual relationship with CCK; and (g) my immediate family members.**
5. **Notice of Potential conflict of interest- This is to advise you that the Cancer Center of Kansas, physicians have a minority investment interest in Preferred PET of Kansas and Mobile PET of Kansas.**

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.

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

Employee Initial: _____

"Dedicated To Quality Care"