WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
ONCOLOGY ASSOCIATES OF OREGON
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

PLEASE COMPLETE THE ENTIRE FORM

Patient Information			
Legal Last Name:	Legal First Name:	Middle Initial:	Date of Birth:
Billing Address (Street, City, State, Zip):			

Primary Insurance Information		
Company:	Subscriber Name:	Subscriber Date of Birth:
Group Number:	ID/Policy Number:	

Secondary Insurance Information		
Company:	Subscriber Name:	Subscriber Date of Birth:
Group Number:	ID/Policy Number:	

Tertiary Insurance Information		
Company:	Subscriber Name:	Subscriber Date of Birth:
Group Number:	ID/Policy Number:	

Assignment of Benefits, Authorization to Release Medical Information:

I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by WVCI, and I hereby assign to WVCI all assignable rights to payment for services rendered by WVCI, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by WVCI, other providers, and insurers for treatment, payment and health care operations purposes.

I understand that in order for WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that WVCI may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize WVCI to obtain my prescription history.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original.

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

Patient Signature: (for patients 17 years of age or younger, parent or guardian MUST sign)	Relationship to Patient:
Printed Name:	Date:

STAFF USE ONLY
RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____