

Please fill out completely:

**SEVU A Division of Ironwood Physicians, P.C. DBA Ironwood Cancer & Research Ctrs; Ironwood Radiology**

**ASSIGNMENT OF BENEFITS (AOB) / FINANCIAL POLICY**

**Patient Name:**

\_\_\_\_\_  
*Last First M.I. Home Telephone*

**House Address:**

**Is Arizona your permanent residence?**

\_\_\_\_\_  
*City State Zip Alternate Telephone*

\_\_\_\_\_  
*Date of Birth Age Sex Social Security Number Marital Status*

**Employer:**

\_\_\_\_\_  
*Name Telephone*

**Are you currently working? Yes or No Retired? Yes or No Disabled? Yes or No**

**Emergency Contact:**

\_\_\_\_\_  
*Name Relationship Telephone*

\_\_\_\_\_  
*Address State Zip Code*

Who Referred Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
referred to us? \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Ins Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by the above insurances. I will inform the billing dept of any change in insurance coverage. I understand that I may be responsible for charges if correct insurance is not provided and billed timely. 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 Ironwood Cancer & Research Centers and the billing dept.
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 Ironwood Cancer & Research Centers. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.
4. 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 Ironwood Cancer & Research Centers. I understand that Ironwood Cancer & Research Ctrs will collect any coinsurance amounts that I owe at time of service. This assignment will remain valid until revoked by me in writing.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Centers.
6. I have received a copy of the financial policy in effect for SEVU and I understand and agree to the terms and conditions.

**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.

**Patient Signature/Responsible Party :** \_\_\_\_\_ **Date:** \_\_\_\_\_

