SONIWALA
HEMATOLOGY-ONCOLOGY
ASSOCIATES
A Roswell Park Community Cancer Practice

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I acknowledge that the information provided in the system is correct and updated to the best of my knowledge.

CONSENT FOR TREATMENT

I give consent to RPCI Oncology, PC to provide treatment to myself or the patient indicated.

ASSIGNMENT OF BENEFITS

If I am entitled to receive healthcare benefits under any insurance policy(ies) from any person or organization, I assign to JMOH all of my rights, title and interest in those benefits for payment of my bills. I understand that I am responsible for knowing the terms and conditions of my insurance coverage, and certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER AND/OR PHYSICIAN (APPLICABLE TO MEDICARE BENEFICIARIES ONLY)

I request payment of authorized Medicare benefits be made on my behalf, to RPCI Oncology, PC, or physician, for any services furnished to me, including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicare Services and its agents any information to determine these benefits or benefits for related services.

FINANCIAL AGREEMENT

I promise to pay RPCI Oncology, PC any amounts under the terms of my insurance coverage including but not limited to, co-payments, co-insurance, deductibles and non-covered services. If I do not have insurance coverage, I understand that the charges for medical services are my personal responsibility and agree to make payment for such amounts. If RPCI Oncology, PC does not receive payment within (30) days from the date such balance is due, the bill may be turned over to an attorney or collection agency. If so, I agree to pay all reasonable collections costs including attorney's fees and/or collection fess in addition to the amounts owed for services.

I have read all of the above statements and accept the terms and conditions as stated.

Patient Name _____ Name of Representative _____

Signature of Patient _____ Date _____ Signature of Representative _____ Date _____