

Children's Center for Cancer and Blood Diseases of Las Vegas

1090 E. Desert Inn Road Suite 200

Las Vegas, Nevada 89109 (702) 732-1493 Fax (702) 732-1080

Assignment of Benefits/Financial Responsibilities

Patient Name: _____ DOB _____

please print

____ I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Children's Center for Cancer and Blood Diseases of Las Vegas for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services including major medical benefits, or services provided to me by Children's Center for Cancer and Blood Diseases of Las Vegas.

____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to Children's Cancer Center and Blood Diseases of Las Vegas, my insurance carrier, state, federal, accreditation agency, insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Children's Cancer Center and Blood Diseases of Las Vegas. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Children's Center for Cancer and Blood Diseases of Las Vegas.

____ It is my responsibility to notify Children's Cancer Center and Blood Diseases of Las Vegas of any changes in my health care coverage.

____ I understand that I am financially responsible to Children's Cancer Center and Blood Diseases of Las Vegas for any charges not covered by health care benefits. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Children's Cancer Center and Blood Diseases of Las Vegas and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for any and all described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services.

____ By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

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

Primary Ins. _____ Phone: () _____

Policy Holder: _____ DOB: _____

SS# _____ Group# _____ Policy# _____

Employer: _____

Secondary Ins. _____ Phone: () _____

Policy Holder: _____ DOB: _____

SS# _____ Group# _____ Policy # _____

Employer: _____

Name of insured person signing below: _____ / _____
please print relationship

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original

Signature of Insured/ Parent/Guardian _____ Date _____

Witness Signature _____ Date _____

Signature and title