CAPITAL REGIONAL
CANCER CENTER

Assignment of Benefits

ALL PATIENTS

I hereby agree to assign payment from my insurance company for claims sent by Capital Regional Cancer Center for medical treatment rendered to me. If payment is mailed to me for claims sent by Capital Regional Cancer Center on my behalf, I will forward payment immediately.

MEDICARE PATIENTS ONLY

I also understand if I have Medicare coverage, I will be responsible for payment of the 20% Medicare does not cover if I have no secondary insurance. I agree that should the amount of the insurance benefits be insufficient to cover my expenses, that I will be responsible for payment of the difference. I understand that statements will be mailed monthly and are payable when received unless prior arrangements have been made with Capital Regional Cancer Center.

CONSENT TO AUTHORIZE USE OF EMAIL AND TEXT FOR PATIENT BILLING AND FINANCIAL OBLIGATIONS.

By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient Billing information.

Acknowledge: _____ **(Initial)** I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge: _____ **(Initial)** I consent to use of text for Patient billings and financial obligation purposes.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. An electronic copy and/or photocopy of this consent shall be considered as valid as the original.

_____ _____

Signature of Patient or qualified representative Date

_____ _____

Relationship if you are not the patient Date

Capital Regional Cancer Center
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