Please fill out completely:

Ironwood Physicians PC DBA Ironwood Cancer & Research Ctrs; Ironwood Radiology

ASSIGNMENT OF BENEFITS / FINANCIAL POLICY

Patient Name:

Last First M.I Home Number Cell Number

House Address:

Is Arizona your permanent residence?

City State Zip

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**

Responsible Party:

Name Relationship Telephone

(Other than patient)

Address State Zip Code

Who referred you to us? Referring Physician: Primary Care Physician: Phone:

Primary Ins: Telephone:

Insured Name: 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 billing dept.
3. If applicable, 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 and its Urology division offices.
6. I authorize my insurance carrier to release information regarding my coverage to Ironwood Cancer & Research Centers.

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:**

Please Print LEGIBLY!!!

Who may receive information regarding your Protected Health Information?

Spouse ____	**Name: ______________________**	**DOB: __________**
Child ____	**Name: ______________________**	**DOB: __________**
	Name: ______________________	**DOB: __________**
	Name: ______________________	**DOB: __________**
	Name: ______________________	**DOB: __________**
Parent ____	**Name: ______________________**	**DOB: __________**
	Name: ______________________	**DOB: __________**
S/O ____	**Name: ______________________**	**DOB: __________**
Friend ____	**Name: ______________________**	**DOB: __________**

May we leave messages on your machine regarding appointments, etc: (Y) (N)

Email Address: ________________________________

Language Spoken: __________

Ethnic Group: ____________ **Race: ____________**

MEDICAL HISTORY

Please list any Medical Problems: (Do Not List Surgeries)	**Date:**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Please list any DRUG Allergies:	**What was the reaction you experienced?**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Please Print LEGIBLY!!!

Please list Surgeries you have had: Side: Date:

Surgery	Side	Date

Please list any SERIOUS family medical problems

Problem:	Relation:

Do you have any children (circle one): Yes No How many? ____________

Are you a current smoker? (Y) (N) How many packs a day? ____________

Are you a former smoker? (Y) (N) How long did you smoke? ____________

Do you chew tobacco? (Y) (N)

Do you drink alcohol? No Socially 1-2 a day 3-4 a day >4 day

Have you ever used illegal drugs? (Y) (N)

If yes, what kinds? ____

Are you sexually active? (Y) (N)

Have you had a sexually transmitted disease? (Y) (N)

If yes, please list and date: ____

Please Print LEGIBLY!!!

Please list ANY and ALL current medication you are taking

Medication Name:	Dosage:	How Often:

Pharmacy Name:____

Pharmacy Location and Phone Number:________________________________