Atlanta Oncology
ASSOCIATES, P.C.

Assignment of Benefits

Atlanta Oncology Associates (FACILITY)

Patient Name: _____

Patient Address: _____

_____

I hereby assign to FACILITY all healthcare and medical benefits payable for care provided to the Patient named above under coverage existing at the time FACILITY provides treatment, which benefits are provided to me by any Payer whatsoever (including, but not limited to, commercial insurance coverage, ERISA-governed benefit plans, governmental health benefits plans, Medicare, Medicaid, and any other source of welfare coverage or insurance) and related rights existing under such coverage. This assignment applies to both past and future medical services provided by FACILITY to the Patient named above. I understand that this assignment is irrevocable. I hereby certify that the Payer information I have supplied FACILITY is true and accurate as of the date of service. I am fully aware that having healthcare coverage does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand different Payers have different requirements for payment including, but not limited to, pre-certifications, authorizations or that the services be medically necessary. I understand that it is my obligation to know my Payer's requirements and ensure that they have been fulfilled. I also understand that my Payer may not pay 100% of the amount of the medical claim and that I may be responsible for any and all amounts not paid by the identified Payer. I agree to notify FACILITY if any of the information I have supplied changes at any time during my treatment.

I hereby authorize FACILITY to submit claims on my behalf to the Payer listed on the copy of the current benefits card I have supplied FACILITY. I hereby instruct and direct my Payer to pay FACILITY directly. If my current coverage prohibits direct payment or assignment to FACILITY for services, I hereby instruct and direct my Payer to make the check payable to me, but to mail it directly to FACILITY for the professional or medical expense benefits allowable that are payable to me under my current coverage under Payer's policy for payment towards the total charges for medical services rendered. Upon receipt of any such check, I authorize FACILITY to deposit to FACILITY's account such check received if such check is made payable to me.

I am hereby making a direct and express assignment of all my rights and benefits (including, but not limited to, payment) under existing coverage to the fullest extent of the law. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of medical service charges over and above this payment (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries). I hereby acknowledge and give my express permission for FACILITY or its legal representative to release any of my patient health information, including privileged information (*i.e.*, mental health, alcohol/drug abuse or HIV/AIDS) for payment purposes. Furthermore, I authorize FACILITY or its legal representative to obtain information concerning my medical benefits directly from Payer (including, but not limited to, the policy or plan governing my benefits).

In the event that my coverage prohibits assignment of certain rights (such as right to file appeals or to file suit in state or federal court) I expressly authorize FACILITY, in its sole discretion, to be my personal representative such that FACILITY may: (1) submit any and all appeals if my Payer denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my Payer; and (3) initiate formal or informal complaints to any State or Federal agency that has jurisdiction over my benefits; this includes express permission for the FACILITY or its legal representative to file suit against Payer for healthcare and medical benefits to which I may be entitled. I also agree that any fines, interest, attorney's fees, or other awarded damages that may be levied against my Payer will be paid to FACILITY for acting as my personal representative.

A photocopy of this Assignment shall be considered effective and valid as the original.

_____ _____

Signature of Patient/Policy Holder Date

_____ _____

Signature of Policy Holder if not Patient Date

_____ _____

Witness Date