

FOX VALLEY HEMATOLOGY & ONCOLOGY, LTD
1710 Randall Rd
Elgin, IL 60123
Main Office

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE - I authorize *Fox Valley Hematology & Oncology, Ltd.* to release to my insurance company, any medical information needed to determine benefits payable for related services

AGREEMENT OF RESPONSIBILITY – I understand that professional services are rendered and **charged to the patient.** **CO-PAY IS DUE AT THE TIME OF SERVICE** . (Co-insurance and deductibles may also be collected at the time of service.) I understand I am financially responsible for charges **not covered by my insurance company.** I also agree to pay any outstanding balance, as well as attorney fees and costs to *Fox Valley Hematology & Oncology, Ltd.* **if this matter is referred to collection.**

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS – I authorize use of this form for release of information needed to process claims to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping obtain payment from my insurance companies. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive monthly statements for any balance due by me. ***I also understand, full payment is required to be made on receipt of your 1st statement*** after insurance has met their obligation.

MEDICARE AUTHORIZATION – I request payment of authorized Medicare benefits be made on my behalf to *Fox Valley Hematology & Oncology, Ltd.*, for any services provided me by that physician/supplier. I authorize holder of medical information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits payable to related services.

I understand my signature requests payment to be made and authorize release of medical information necessary to pay claims. If ‘other health insurance’ is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge of determination of the Medicare carrier as the full charge –**the patient is responsible for deductible, co-insurance and non covered services.** Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP/SUPPLEMENTAL AUTHORIZATION - I request payment of authorized Medigap/Supplemental benefits on my behalf to *Fox Valley Hematology & Oncology, Ltd.* for any services furnished me by that physician/supplier. I authorize holder of my medical information to release to Medigap/Supplemental and its agents, any information needed to determine these benefits or the benefits payable to related services.

Signature of patient or representative

Please read and sign 2nd page (of this notice) too.

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AUTHORIZATION – INSURANCE/FINANCIAL MATTERS - By my signature, I also authorize ***Fox Valley Hematology & Oncology, Ltd.*** to discuss financial/insurance matters on my behalf with those persons designated below

1. _____

2. _____

(Please PRINT persons' complete names & relationship)

Patient Name : _____

Patient Signature _____ **Date** _____

Witness _____