



San Diego
PACIFIC ONCOLOGY & HEMATOLOGY
 Associates Inc.



Premiere Oncology Network Affiliate in
 San Diego, Santa Monica and Phoenix

CONSENT TO PROCEDURES

The undersigned consents to the services provided by San Diego Pacific Oncology & Hematology Associates, Inc. The undersigned acknowledges that these services have been adequately explained, and all questions have been answered.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be provided to the patient, he/she is obligated to pay the charges. We bill patients' insurance as a courtesy, however, it is the patients' ultimate responsibility for payment for services provided.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment of the insurance benefits to which I may be entitled directly to San Diego Pacific Oncology & Hematology Associates, Inc. Requested information may be released to the Insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care Insurances generally require that a representative, often a Primary Care Physician, authorize services and diagnostic procedures before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payment if you receive services that are not authorized as required by your plan.

NOTICE TO MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process claims. I also request payment of government benefits to the party who accepts assignment.

Patient Name (Print) _____

Patient Signature _____ Date: _____

Or

Designated agent's signature: _____ Date: _____

Relationship to patient: _____

A photocopy of this form may be deemed as valid