

ASSIGNMENT OF BENEFITS



Proton Therapy Center

Patient Name _____

Date of Birth _____

FOR OFFICE USE ONLY
AFFIX PATIENT LABEL HERE

Please initial to confirm your reading and understanding of each statement.

_____ I acknowledge that the IU Health Proton Therapy Center has provided Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices for Protected Information.

_____ I authorize the IU Health Proton Therapy Center to release medical records pertaining to my treatment to my insurance company or other entity directly concerned with the payment or authorization of costs for my medical treatment.

_____ I authorize payment directly to the IU Health Proton Therapy Center and/or any provider that renders service for which an assignment is applicable. I understand I am financially responsible to the IU Health Proton Therapy Center, or my treating healthcare provider, for charges not covered in this authorization.

_____ I acknowledge that it is my responsibility to understand the policies and benefits provided by my insurance company. I further acknowledge that the IU Health Proton Therapy Center staff will calculate co-payments, out-of-pocket maximums, and amounts due from patients based on information my insurance company has provided to the IU Health Proton Therapy Center. In the event that my insurance company has provided inaccurate or incomplete information, I will be responsible for any unpaid charges.

_____ If I am eligible for Medicare benefits, I request that payment of authorized Medicare benefits be made to the IU Health Proton Therapy Center for any services furnished to me by the IU Health Proton Therapy Center.

_____ I understand that appointments may be scheduled with health care providers outside of the IU Health Proton Therapy Center. These may include, but not be limited to, personal physician, surgeon, dentist, patient-specific device manufacturer, anesthesiologist, pathologist, emergency physician and radiologist. These services will be billed to my insurance company by those health care providers. If these services are not cover by my insurance company, I am responsible for payment(s) to the provider(s). It is my responsibility to verify in- or out-of-network services.

_____ In the event that pre-certification is required by my insurance company, it is my responsibility to verify that pre-certification is obtained.

_____ I agree, in consideration of the services rendered to me, that I am obligated to pay the amounts due to the IU Health Proton Therapy Center, and treating health care providers, in accordance with the regular rates and terms of said providers. Should an account be referred for collection, the undersigned shall pay additional reasonable attorney's fees and related collection expenses incurred in addition to the amounts due.

Signed in agreement by me, the legal contracting party, under Indiana State law:

Patient Signature _____

Date _____

Guardian Signature _____

Date _____

Relationship Parent Legal Guardian Court Appointed Representative Other _____

IU Health Proton Therapy Center Staff Signature _____

Date _____