STOCKTON HEMATOLOGY ONCOLOGY MEDICAL GROUP, INC.

ASSIGNMENT OF BENEFITS AND TREATMENT CONSENT

I understand that my health information may be used for treatment, payment, and health care operations purposes and I have the right to receive a notice of information practices, to see a copy of my own health information, to amend my health information if it is inaccurate and to receive an accounting of disclosures. _____

I herby authorize Stockton Hematology Oncology Medical Group to furnish my Insurance Company all information, which said Insurance Company might request concerning my illness/injury/therapy._____

I herby authorize payment of insurance benefits otherwise payable to me, directly to Stockton Hematology Oncology Medical Group

I understand I am financially responsible to said Doctor(s) for co-payments and charger not covered by this assignment.

I understand that if my insurance coverage lapses for whatever reason, I will be financially responsible for all services rendered.

I herby authorize Stockton Hematology Oncology Medical Group Physicians to render my medical treatment, laboratory testing, and x-rays as deemed necessary by my physician.

I accept the responsibility for all financial matters including insurance eligibility confirmation and timely payment from my insurance company. I understand that if I do not provide the correct insurance information I can be held responsible for payment of the charges incurred for physician visits and/or chemotherapy visits.

Patient Name_:_____
Date: _____ Signed:_____

Relationship to Patient: _____