ONCOLOGY SPECIALISTS
OF CHARLOTTE, PA

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OncologyCharlotte.com

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AUTHORIZATION FORM

Assignment of Benefits

I, the undersigned, have insurance and assign directly to the physicians of Oncology Specialists of Charlotte, P.A. all benefits, if any, otherwise payable to me for services rendered.

Release of Medical Information

I hereby authorize Oncology Specialists of Charlotte to release all information necessary to secure payment of benefits. I authorize the use of the below signature on all insurance submissions whether manual or electronic. I also authorize Oncology Specialists of Charlotte to release my medical information, as necessary, to other physicians or medical facilities that I am being referred to.

I also request the following individuals to have access to my medical records, information on my condition and any other Protected Health Information, as needed or requested:

Name_____ Relation _____

Name_____ Relation _____

Name_____ Relation _____

Financial Agreement

I acknowledge that payment is due at time of treatment, unless other arrangements are made. I accept full responsibility for all charges not covered by my insurance company.

Treatment Authorization

I hereby authorize such examinations, treatments, medications, surgical procedures and all other medical procedures as may be prescribed by the physician in charge of my care.

Privacy Practices

I hereby acknowledge that a copy of all Privacy Practices and Billing Procedures for Oncology Specialists of Charlotte, P.A. has been made available to me.

Patient's Signature _____ Date_____

Printed Name _____