

Montana Cancer Specialists

PLEASE PRINT THE FOLLOWING:

Last Name *First Name*

Address

City *State* *Zip*

Birthdate

I acknowledge that Montana Cancer Specialists may release to third party payers requested medical and/or other information necessary to process my claims(s). I hereby assign to Montana Cancer Specialists all benefits which are or shall become payable from any third party payer who is responsible for payment of my Montana Cancer Specialists expenses. I authorize and direct all third party payers to pay all benefits directly to Montana Cancer Specialists.

This may include health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

Patient and/or persons legally and financially responsible for patient's medical bills agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Montana Cancer Specialists is free to declare the entire balance to be due and payable if any scheduled payments are missed. The undersigned agrees to pay all costs of collection, including reasonable attorney's fees, if the account is not paid timely.

I authorize treatment of the person named above and agree to pay all fees and charges for any services.

Patient Signature

Date

Authorized Representative Signature

Date

Relationship to Patient