# CARTI Oncology Solutions, LLC

**P. O. Box 56650, Little Rock, AR 72215-6650**
**Phone: (501) 906-3000**

**Physicians' Release and Assignment for Patients at all six of these Locations:**
**CARTI/Baptist • CARTI Cancer Center • CARTI/Conway • CARTI/NLR • CARTI/Searcy • CARTI/SVI**

## Authorization to Pay Benefits to CARTI Oncology Solutions, LLC

**Provider** _____ **Patient** _____

**CARTI Oncology Solutions, LLC**
**P.O. Box 56650**
**Little Rock, AR 72215-6650**

Patient Label

**ASSUMPTION OF RESPONSIBILITY:** The undersigned agrees, whether he/she signs as guarantor or as patient, that in consideration of services to be rendered to the patient named above he/she hereby obligates himself/herself and agrees to pay upon demand to above named provider all charges for such services and incidentals incurred by said patient. The undersigned also authorizes CARTI Oncology Solutions to obtain any financial information if financial terms are requested.

**MEDICARE/MEDICAID PATIENT CERTIFICATION:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any inf01mation needed for this or a related claim. I request that payment of authorized benefits be made on my behalf to CARTI Oncology Solutions, LLC.

**AUTHORIZATION TO RECEIVE PAYMENTS:** I authorize CARTI Oncology Solutions, LLC to receive payment from my insurance company or companies on my behalf.

**AUTHORIZATION TO RELEASE INFORMATION:** The undersigned hereby authorizes said CARTI Oncology Solutions, LLC to release all information pertaining to patient's treatment to his/her or their insurance company or companies.

**MY SIGNATURE INDICATES I HAVE READ AND APPROVE ALL OF THE ABOVE.**

**Signed:** _____ **(PATIENT)**

**Signed:** _____ **(GUARANTOR)**

**Date:** _____ **Witness:** _____

Revised 1/1/2016