

# THE CENTER FOR CANCER AND BLOOD DISORDERS

Please be advised that it is your responsibility as the patient to notify us of changes in **home address/telephone number, Primary Care Physician or Insurance Carrier.**

You have provided The Center for Cancer and Blood Disorders with certain insurance information. We will verify your benefits; should the information you provided us differ from what we obtain, you could be responsible for any services rendered. If your insurance requires a referral, we will do our best to obtain those referrals from your Primary Care Physician (PCP), but ultimately the responsibility belongs to you, the patient.

Please sign below to indicate that you read and understand the above and will notify us of any changes immediately.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Patient Account Number: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_