RCCA
REGIONAL CANCER CARE ASSOCIATES

What is Financial Advocacy:

At Regional Cancer Care Associates, we understand that navigating healthcare expenses can be challenging, especially during times of medical need. That's why we offer Patient Financial Assistance, a compassionate program designed to provide support and relief to individuals facing financial hardship.

Patient Financial Assistance is more than just financial aid; it's a commitment to ensuring that everyone has access to the care they need, regardless of their ability to pay. Whether it's covering medical bills, co-payments, or other healthcare-related expenses, our program is here to lend a helping hand during difficult times.

On the next page, we're seeking financial details in case you need assistance covering any out-of-pocket expenses your insurance may deem you responsible for. Should you or a family member have inquiries about financial aid, please feel free to contact our office. We're committed to guiding you through this process and offering support at every turn.

Consent for Patient Financial Assistance

Date: _____

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Physician: _____

# of dependents:_____

Annual Gross Income: $_____

Other Dependents' Income (Spouse/Children) $_____

I understand that this information is confidential unless specifically released by me, the patient.

I have received a copy of the Privacy Rules from (Practice / Facility) and authorize (Practice / Facility) to release my personal information to Patient Assistance Foundations or Copay Assistance Programs. I grant permission to (Practice / Facility) to act on my behalf to apply for any and all assistance programs necessary to help me with my financial needs. I agree to provide proof of income upon request by (Practice / Facility), or any other foundation or assistance program.

I understand that all Foundation or Copay assistance is subject to availability of funds at the time funds are requested and that this is not a guarantee of payment.

Enrollment in a Foundation or Drug Assistance program does not guarantee that assistance will be obtained. Assistance is subject to approval under the program guidelines. The programs also reserve the right to change or terminate the program without prior notice. In the event that a drug or date of service is not covered by program assistance, the patient will be fully responsible for the cost.

_____ _____

Patient's Signature Date

I decline to release the requested information or consent to the above:

_____ _____

Patient's Signature Date