

F.A.C.T.

Financial Assistance for Cancer Treatment
P.O.Box 624 Tiffin, OH 44883
Telephone: (419) 937-2540

Patient Application Form

Please complete this form, **sign and date it**. Return it along with your completed **signed and dated** Physician Authorization Form to F.A.C.T. at the above address.

Name _____ Social Security # _____

Address _____ Sex _____

City, State, Zip _____ Date of Birth _____

Telephone _____ E-Mail Address _____

Next of Kin (contact person) _____

Address _____

City, State, Zip _____ Telephone _____

Physician _____

Address _____

City, State, Zip _____ Telephone _____

Diagnosis _____

Informed Consent

All information on this form is strictly confidential and will be treated as such by F.A.C.T. I authorize F.A.C.T. to discuss my care and treatment related to payment of claims to verify such claims submitted are cancer related. I have reviewed and understand The Service and Rehabilitation Policy of F.A.C.T. of which a copy has been provided to me.

Signature _____ Date _____

Serving Seneca County Cancer Patients