

**PATIENT REGISTRATION FORM**

Please bring this completed form and your insurance cards to your appointment

Your Physician:  Dr. John Sylvester  Dr. Peter Grimm

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone:(\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  Yes, you may discuss my billing and medical details with this individual

Race: Caucasian African American Asian Native American Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMERGENCY CONTACT or LEGAL NEXT OF KIN:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  Yes, you may discuss my billing and medical details with this individual

Relationship: \_\_\_\_\_ Cell #: \_\_\_\_\_

**INSURANCE INFORMATION**

Please provide a copy of your insurance card(s) to the receptionist. If your card is present, you may disregard the areas outlined with two double lines below. If you do not have your insurance card present you MUST complete all information within the Insurance Information box.

PRIMARY INSURANCE – Effective ____ / ____ / ____		SECONDARY INSURANCE – Effective ____ / ____ / ____	
Insurance Name:		Insurance Name:	
Policy/Member #:		Policy/Member #:	
Group/Plan #:		Group/Plan #:	
Subscriber Name:		Subscriber Name:	
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Subscriber Info: <input type="checkbox"/> M <input type="checkbox"/> F Birth Date ____ / ____ / ____		Subscriber Info: <input type="checkbox"/> M <input type="checkbox"/> F Birth Date ____ / ____ / ____	
Copay Amount: \$		Copay Amount: \$	
Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Claims Address:		Claims Address:	
Phone #:		Phone #:	
Do we have permission to:			
a) Leave a message on your answering machine at home?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Leave a message on your cell phone?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Contact you by email?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
d) Discuss your medical condition/billing with any member(s) of your household?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, whom:			

Please fill in the complete names, addresses and phone numbers of your physicians

Primary Care Physician	Name:			
	Address:			
	City:	State:	Zip:	
	Tel:	Fax:		
Urologist	Name:			
	Address:			
	City:	State:	Zip:	
	Tel:	Fax:		
Other	Name:			
	Address:			
	City:	State:	Zip:	
	Tel:	Fax:		

*How Did You Come To Choose SPCC For Your Care?*

Referred By A Physician	Name:			
	Address:			
	City:	State:	Zip:	
	Tel:	Fax:		
Learned About SPCC From:	Family member:	_____		
	Friend:	_____		
	Our Website:	_____		
	Other Internet Site:	_____		
	Newspaper Ad:	_____		
	Other (please specify):	_____		

**CONTRACTED INSURANCE:** All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits, deductibles, and co-insurance are your responsibility. Payment for any patient responsibility is due upon receipt of your monthly statement.

**CO-PAYS:** All co-pays are expected at the time the service is rendered. It is the patient's responsibility to notify the receptionist upon arrival that a co-pay is due.

**NON-CONTRACTED INSURANCE:** All charges are considered patient responsibility if we are not contracted with your insurance. A claim will be filled as a courtesy; however, a contractual adjustment will not apply. Payment is due upon receipt of your monthly statement.

**PRIVATE PAY:** The undersigned agrees, whether signing as agent or as patient, to be financially responsible to PCTC for services rendered. I further understand that the payment of said charges are due two weeks before the permanent seed implant.

**RETURNED CHECKS:** There will be a \$25.00 charge for all returned checks.

**BENEFITS/COVERAGE:** It is your responsibility to understand your insurance benefits. Insurance coverage is not a guarantee of payment for services provided including, preventive, routine screening, vaccinations, or procedures considered not medically necessary and/or cosmetic in nature.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize the Prostate Cancer Treatment Center, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, government agency or third party payer which is liable to the clinic for the charges or who may be responsible for determining the necessity, appropriateness, or amount related to the clinic's treatment or charge, including medical service companies, insurance companies, Social Security Administration, intermediaries and the State Department of Health & Human Services when a patient is a Medicare or Medicaid recipient. This consent will expire upon final payment relative to this admission.

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Signature