

PATIENT REGISTRATION FORM

Please bring this completed form and your insurance cards to your appointment
Your Physician: 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: _____

Relationship: _____ Cell #: _____

Yes, you may discuss my billing and medical details with this individual

HOW DID YOU HEAR ABOUT OUR CLINIC?

Dr. _____ Family Friend _____ PCTC Website Internet Search Other _____

OTHER PROVIDERS:

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

Urologist: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

Other: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

COMMUNICATIONS:

Do we have permission to:

- a) Leave a message on your answering machine at home? Yes No
- b) Leave a message on your cell phone? Yes No
- c) Contact you by email? Yes No
- d) Contact you via email regarding PCTC updates? Yes No

INSURANCE INFORMATION

PRIMARY INS: _____ SECONDARY INS _____

****If you have your insurance cards with you and the office is able to make a copy you can skip this section.**

Policy/Member #: _____ Policy/Member #: _____

Group/Plan #: _____ Group/Plan #: _____

Subscriber Name: _____ Subscriber Name: _____

Relation to Patient: Self Spouse Other Relation to Patient: Self Spouse Other

Subscriber Info: M F Birth Date ____ / ____ / ____ Subscriber Info: M F Birth Date ____ / ____ / ____

Copay: \$ _____ Referral Required: Yes No Copay: \$ _____ Referral Required: Yes No

Claims Address: _____ Claims Address: _____

Phone #: _____ Phone #: _____

ACKNOWLEDGEMENTS: (PLEASE INITIAL EACH)

_____ RESEARCH DATABASE: I acknowledge consent to be added to the BrachyBase research database.

NOTE: All participant information is kept confidential and anonymous.

_____ PATIENT PHONE CALLS: PCTC Providers are happy to take your call. However, patient phone calls with providers are a non-covered service and cannot be billed to my insurance carrier. I understand that I must pay for phone calls with the provider. Information regarding call pricing is provided in our Call Policy and will be made available to you.

_____ 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.

_____ REFERRALS/AUTHORIZATIONS: It is your responsibility to inform the office if your plan required a referral or authorization. Appointments may need to be rescheduled if the required referral is not in place from your PCP. If you are seen and a referral is not in place you may be responsible for the balance due.

_____ 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.

_____ Patient Signature

_____ Date