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_____ □ PCCS Website □ Internet Search □ Other_____ □ Dr. Grimm's (E-mail) PCA Updates _____

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 PCCS updates? ❑ Yes ❑ No

Please continue filling out our registration form on the other side➔

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 ____ /____ /_____

Copy: $_____ Referral Required: ❑ Yes ❑ No Copy: $_____ 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: PCCS 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 PCCS 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 seena dn 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 Center of Seattle, 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