Biocare Infusion
ONCOLOGY & THERAPEUTICS

PATIENT REGISTRATION FORM

371 E Paces Ferry Road, Suite 640, Atlanta, GA 30305

Patient Information:

Patient Name:_____ Social Security Number:____-_____- _____

Date of Birth:_____/_____/_____ **Sex: M/F (Circle one)** Married/Single/Divorced/Widow

Spouse

Name:_____

Address: _____

Race:_____ Religion:_____ Primary Language:_____

Home Phone: (___) _____- ____ Work Phone: (____) _____-____ Cell Phone: (___)_____-___

Primary Phone:_____ **E-mail Address:**_____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment Reminders, administrative updates and health bulletins) Yes? No?

Other Information:

Primary Care Physician:_____

Who referred you?_____

Preferred Pharmacy:

Pharmacy

Name:_____Address:_____

Pharmacy Phone:(____) _____ Pharmacy Fax:(___)

_____

Person Responsible for Bill or Parent (Complete only if Different from Patient)

Guarantor Name:_____ Social Security Number: _____-_____-_____

Relationship to Patient:(please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth:___/____/___

Address:_____ Phone Number:_____

Emergency Contact:

Name:_____

Address:_____

Home Phone:(__) _____-_____ Work Phone: (__) _____ -_____

Relationship:_____

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INSURANCE INFORMATION

Insurance Company:_____ Policy Holder_____

Address:_____ Group Number:_____

Policy Holder ID#:_____Policy Holder's DOB:_____/____/____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Biocare Oncology & Therapeutics. I acknowledge that I am financially responsible payment whether or not covered by insurance. (If under 18, parent or legal guardian must sign).

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGMENT OF RECEIPT

I, _____, hereby acknowledge that BOT has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient/Guarantor Signature* _____Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. If not signed, please provide a reason why the acknowledgment was not obtained.

Witness_____Date_____

CONSENT TO RELEASE INFORMATION

In the event I can't be reached, I, _____give permission for a representative from BOT, to speak with family member (s) or companion (s) listed below regarding care or tests results.

Name _____Phone_____

Relationship _____

Name _____Phone_____

Relationship _____

Is it OK to leave results or information on your voicemail? _____YES _____ NO

Patient /Guarantor Signature*_____ Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

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CONSENT TO CORRESPOND ELECTRONICALLY

While BOT takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a BOT provider regarding my medical care, that BOT representative has my permission to correspond via that email address.

I give permission for a BOT clinical staff member to email me at _____regarding my care.

Patient/Guarantor Signature* _____ Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

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PATIENT REGISTRATION FORM

Patient Name_____ **Account #**_____**Date**_____
Reason for today's visit_____
Who is your primary care physician?_____
Who referred you to us?_____

MEDICAL HISTORY
Please check those medical **conditions that apply to you** (this information is **kept confidential).**

- Heart Disease
- Heart Murmur/Artificial heart valve
- Stroke
- Gastrointestinal Problems
- Hypertension
- Poor Healing
- Diabetes .
- Endocrine or Hormone Stroke
- Problems
- Skin Cancer
- Seizure Disorders
- Cancer
- Herpes Infections
- Arthritis
- Breathing Difficulties
- HIV Positive
- Sexually Transmitted Diseases
- Tuberculosis
- Shingles
- Hepatitis/Liver disease/Jaundice
- Blood Clotting Disorders
- Asthma / Hayfever
- Kidney Disease
- Other (Please explain below)
- Ulcers
- Seasonal Allergies

Please explain **any conditions checked above**_____
Please list ALL medications you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

_____
ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____
Are you pregnant or nursing?_____ ___Yes __No
If no to pregnant are you trying to get pregnant?_____:_____ ___Yes ___No
When was your last flu shot? Date?_____
Do you use tobacco? Yes___No___ (Such as smokeless tobacco products, cigars, or cigarettes)
If yes, how much?_____
Do you drink alcohol? ___ Yes ____ No
Are you taking a blood thinner, like Coumadin or aspirin? ___ Yes ____ No
If so, which? _____
Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure?
___Yes ____ No
Do you have a pacemaker? ___Yes ____ No

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature* _____ Date _____

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FINANCIAL POLICY AGREEMENT

_____ _____ _____
PATIENT NAME (PLEASE PRINT) CHART/ACCOUNT NUMBER

Biocare Oncology & Therapeutics is committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we have adopted the following financial policies and ask that you adhere to the following guidelines:

1: You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a $45.00 returned check charge being added to your account. _____(initials)

2: It is your responsibility to provide us with your current address, telephone number, an insurance information at each visit.

3: It is your responsibility to contact your insurance carrier to confirm that our providers participate in your plan, if you visit our center(s) and they are not currently on your plan, you will be responsible for payment in full.

4: All co-payments and deductibles are due at time of service. A $30.00 service fee will be charged for failure to pay the co-payment or deductible at time of service. We also reserve the right to refuse to allow any follow up visits if an outstanding balance exists. _ _____ (initials)

5: If you miss your appointment, you will be charged a NO-SHOW fee of $30.00 for each appointment missed. All cancellations must be at least 1 business day prior to the time of the visit to not be charged a NO-SHOW fee. Even rescheduling less than 24 hours prior to your appointment will result in the charge of the NO-SHOW fee. _____(initials)

6: If your plan requires a referral it is your responsibility to obtain this prior to being seen by the infusion center. If we are required to obtain the referral for you, please notify our office 72 hours prior to the visit so that we have ample time to acquire this information from your insurance company.

FINANCIAL POLICY AGREEMENT

7: Laboratory services may be provided by a contracted outside reference lab. Lab/Path charges not covered by your medical insurance will be billed to you by an independent lab/path billing service. I accept responsibility for valid lab/path charges not covered by my medical insurance plan.

8: All medical record requests must be in writing and received in our office 1 week prior to the date needed. Records over 10 pages will only be mailed, not faxed and all medical record requests will have a fee associated based on the number of pages. The usual range of fees for this service is $10-$40, however, very large files may actually require a fee greater than $40.

9: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on where the service is performed. By law, you are responsible for these amounts, as well as for any non-covered services outlined in your health plan. BOT will submit primary, secondary and tertiary claims of our contracted payers on your behalf, but you the patient are responsible for any co-payments, co-insurance and all deductibles. If you did not pay these fees at the time of service they are due in full upon receiving a statement with amount owed from our office or billing service. _____(initials)

10: Refunds will be processed within 4-5 weeks after any overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but have made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company._____ (initials)

11: Our office specializes in Oncology and Therapeutic infusions which means a vast majority of our patients require certain administrative services from us for you that are not covered by your insurance company and that you will be responsible for. Due to that reason our office is collecting an optional Administrative Services Fee (ASF) of $50.00 annually. If elected, the ASF will be effective for a 12 month period from the date you signed. The ASF is only intended to cover the costs of certain administrative services we may provide that are **not covered by your** insurance. You are not required to pay the ASF; however, if you choose not to pay the optional fee, you will be charged for all non-covered administrative services, as needed. A list of administrative services with associated fees is listed below. _____ (initials)

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ADMINISTRATIVE SERVICES FEE (ASF)

Services you are responsible for paying as needed and/or have requested. Includes but not limited to:

1: Completion of all patient requested forms, letters and/or documents requiring the provider's signature; which also include administrative forms requested by third parties, (excludes your insurance company and/or another physician) will be provided to you at **$50 per form.**

Examples of the forms you the patient may request us to complete and provide:

a. Employer
b. Patient Assistance forms

2: Computer-generated reports (claims, statements, payment history, etc.) patient requests, will be charged up to $15 per report provided. These reports are sometimes needed for flex benefit plans and/or yearly tax needs.

3: **Appeals or Pro-longed Prior Authorisation process are not required of an infusion center:** Once a medication is decided upon by your doctor, your insurance company may decide that you require a prior authorization prior to covering that medication. Becoming familiar with the prior authorization process may enable you to get your medicine approved faster. But beware, not all medicines will be approved. Even if we and you do everything right, the insurance company may still refuse to cover your medicine. In the end, the insurance company is the one making the decision. To resolve this issue your physician may just change your prescription to another drug that does not require a prior approval. Since your doctor is not aware what your specific insurance company has on their formulary, this step will be done when possible and is an easy but sometimes timely solution. Other times a prior authorization will be completed which entails sending over paperwork 'requesting a specific medication to your insurance company. The waiting process begins and the office will wait for further instructions from your insurance company, usually a request regarding medical records, as well as a reason why the prescribing physician would like to use that specific medication. Once all that is done a review and decision will occur, this process may take 2-3 weeks, in some circumstances, it can actually take months. Depending on the PA decision and your specific request or demand for that particular medication and/or appeals process may begin. The appeals process is a very lengthy and a time consuming process in which administrative services and physician services are not covered by your insurance, the time and effort required to fight an appeals process can be months.

This process is also not required of an infusion center as standard of care. If ASF was not elected an appeal fee of $100.00 per appeal will be charged, regardless of the outcome of the appeal.

4: The ASF does NOT include medical records copying and forwarding of medical records, that is a separate fee.

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PLEASE ACCEPT ONE OF THE FOLLOWING OPTIONS:

1) I ACCEPT THE FINANCIAL POLICY THE **INCLUDES** PAYMENT OF THE ASF. IF ELECTED, THE ASF WILL BE EFFECTIVE FOR A 12 MONTH PERIOD FROM THE DATE SIGNED.

2) I ACCEPT THE FINANCIAL POLICY, BUT CHOOSE NOT TO PAY THE ASF. I UNDERSTAND THAT I WILL NOT BE GIVEN THE CHANCE TO PAY THE ASF FEE AT A LATER DATE DURING THIS 12 MONTH PERIOD FROM THE DATE SIGNED.

PATIENT/GUARANTOR CHOOSE OPTION_____

_____

PATIENT/GUARANTOR SIGNATURE DATE

Remember if you choose NOT to pay the ASF fees today, you will be charged the administrative services when you request them. They will have to be paid prior to receiving the service.