BARDMOOR CANCER CENTER

PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

☐ **Female** ☐ **Male** **Social Security #** _____-_____-_____ **Date of Birth:** _____ **Age:** _____

Last Name:_____ **First Name:**_____ **Middle:**_____

Address: _____ **Apt/Lot #** _____

City: _____ **State:** _____ **Zip:** _____

[**Alternate Address:** _____ **City:**_____**State:** _____**Zip:** _____]

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Cell Phone Carrier: _____ **Email Address:** _____

RACE: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other ☐ Refuse to Report

ETHNICITY: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other **Preferred Language:** _____

➢ **Medical Communication Preference:** ☐ Print ☐ Email ☐ Patient Portal ☐ Portable Media

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer's Name: _____ ***Occupation:*** _____

Address: _____***Phone #*** _____

PHYSICIANS

Referred to us by: ***(please check one box)*** ☐ *Dr. (Please provide name below)* ☐ *Insurance Plan* ☐ *Hospital*

Primary Care Physician: _____

Referring Physician: _____

All Specialty Physicians (Cardiologist, Dermatologist, Urologist, Gynecologist, etc…).

1._____2._____

3._____4._____

EMERGENCY CONTACT INFORMATION

Contact Name: _____**Phone #** _____ **Relationship to Patient:** _____

Contact Name: _____**Phone #** _____ **Relationship to Patient:** _____

Patient/Guardian Signature: _____ **Date:** _____

BARDMOOR CANCER CENTER

PATIENT REGISTRATION FORM

(Please Print Clearly)

INSURANCE INFORMATION

Primary Insurance Company: **_____ Policy Holder's Name: _____**

Social Security Number: _____ Date of Birth: _____

Member ID: _____Group # _____Relationship to Policy Holder- ☐ Self ☐ Spouse ☐Other

Employer: _____ Employer Address: _____ Employer Phone # _____

Name of Secondary Insurance: **_____ Policy Holder's Name: _____**

Social Security Number: _____ Date of Birth: _____

Member ID: _____Group # _____Relationship to Policy Holder- ☐ Self ☐ Spouse ☐Other

Employer: _____ Employer Address: _____ Employer Phone # _____

**** I certify the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am directly responsible for any balance. I also authorize BARDMOOR CANCER CENTER or insurance company to release any information required to process my claim.***

Patient/Guardian Signature: _____ Date: _____

(Continue to next page)

BARDMOOR CANCER CENTER

Medical History Questionnaire

Patient Name: _____ **Today's Date:** _____

ALLERGIES

No known allergies, please check box. ☐

1. Medication: _____ Reaction: _____
2. Medication: _____ Reaction: _____
3. Other: _____Reaction: _____

MEDICATIONS

List any medications and dosage you take, including oral contraceptives, aspirin, vitamins, over the counter medications & home remedies. *(Attach list if necessary)*

Medication	**Dosage**	**Frequency**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

Preferred Pharmacy Name: _____ **Phone#**_____

Address: _____

(Continue to next page)

BARDMOOR CANCER CENTER

Medical History Questionnaire

Patient Name: _____ **Today's Date:** _____

DISEASE/MEDICAL CONDITIONS

***Please check off any of these conditions that you currently have or have had in the past.**

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ BPH (Enlarged Prostate)
- ☐ Bipolar Disorder
- ☐ Bleeding problem
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Degenerative Joint Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Emphysema
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ HIV
- ☐ High Cholesterol
- ☐ Hyperglycemia
- ☐ Hyperlipidemia
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Macular Degeneration
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Schizophrenia
- ☐ Seizure
- ☐ Shingles
- ☐ Stroke
- ☐ Uterine Fibroids

Other conditions not listed:

1._____ 2._____

3._____ 4._____

SURGERIES

Please list all surgeries, biopsies and hospitalizations:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Last colonoscopy exam date: _____ ☐ Never had colonoscopy.

Recent imaging scan: ☐ PET/CT ☐ CT ☐ MRI ☐ Bone scan ☐ Mammogram

Name of facility: _____

BARDMOOR CANCER CENTER

Medical History Questionnaire

MEDICAL HISTORY

Gynecologic (Females only):

Number of pregnancies _____ Number of births_____

Menopause status: ☐ Pre ☐ Peri ☐ Post ☐ Unknown

Menses start age: _____ Age at menopause: _____

Last PAP exam: _____ Last Mammogram exam: _____

Any hormone use? No ☐ Yes ☐ : _____.

FAMILY HISTORY

Please note any family history of cancer (parents, grandparents, siblings, etc.).

Family Member: _____ Type of Cancer: _____

Family Member: _____ Type of Cancer: _____

Family Member: _____ Type of Cancer: _____

Family Member: _____ Type of Cancer: _____

SOCIAL HISTORY

Smoke tobacco products: ☐ Yes. Number of packs/day _____, how many years? _____ .
☐ Occasionally ☐ Yes, but quit (number of years quit _____). ☐ Never

Drink alcohol: ☐ Never ☐ Yes ☐ Occasionally
☐ Yes, but quit (# year's quit_____)Number of days/week _____, number of drinks/day _____.

Illegal drug use: ☐ Yes, type _____ ☐ Occasionally ☐ Never

LEGAL DOCUMENTATION

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Power of Attorney? If yes, please state name:

_____Relationship to Patient:_____

I certify that the information above is true and accurate to the best of my knowledge. I the patient hold the responsibility and will notify the Doctor and/or staff of any changes or additions at any subsequent visits to assure accuracy of my personal records.

Patient/Guardian Signature: _____ Date: _____

BARDMOOR CANCER CENTER
8787 BRYAN DAIRY ROAD, SUITE 120, LARGO, FL 33777
PHONE #: (727)320-0200 FAX #: (727)394-8934

AUTORIZATION FOR RELEASE OF MEDICAL RECORDS

(Doctors Office use only)

TO: _____	**FROM**: (Office Member Initials): _____
RE: _____	**DATE: _____**
NOTE:	

***Patient to fill out below:**

I, _____, _____, _____;
(Patients name) (Date of Birth) (Last 4 of SSN#)

Authorize any physician or surgeon to release all medical information which is in their possession, to: **Dr. Kevin Tralins at Bardmoor Cancer Center 8787 Bryan Dairy Road, suite 120, Largo, FL 33777,** for the purpose of evaluation and/or treatment.

I further authorize **Dr. Kevin Tralins** to release said medical records to any authorized representative from my health insurance company, upon their written request for the purpose of case management, quality assurance, utilization review or compliance with a judicial or agency order. I fully understand that my medical records are privileged and confidential information, and may not be disclosed without my prior written consent, except as required by law.

Patient's Signature_____ Date: _____

Patient Consent to the Use & Disclosure of Health Information for Treatment, Payment, or Health Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care & treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent
- The right to restrict or revoke the use disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Restrictions:

** I request the following restrictions to the use or disclosure of my health information:

_____ .

**Please tell us (using names) with whom we may discuss your protected health information with:
(Example: Spouse, Children, other relatives, Friends, or Caregivers)

1._____ 2._____

3._____ 4._____

Messages/Appointment reminders/Billing Calls:

May we leave a message at your **Home** using Doctor's/Practice name: YES ☐ NO ☐
May we leave a message at your ***Work*** using Doctor's/Practice name: YES ☐ NO ☐
**Messages will be of a non-invasive nature, such as, appointment reminders*

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. Referrals to other healthcare providers, Labs, and/or other individuals or agencies as permitted or required by state of federal law.

I fully understand and accept the information provided by this consent. **(Sign Below)**

_____	_____	_____
Print Name	**Signature**	**Date**

**If other than patient is signing, are you the Parent, Legal Guardian, Custodian, or have Power of Attorney for this patient, for treatment, payment or healthcare operations?* YES ☐ NO ☐

FOR OFFICE USE ONLY

☐ Patient refused to sign the consent form.
☐ Restrictions were added by the patient (see restrictions listed above)
☐"Consent Form" received and reviewed by _____ on (date) _____.
And placed in the patient's medical record on (date) _____.

LIFETIME PATIENT AUTHORIZATION RECORD

Thank you for choosing Bardmoor Cancer Center as your health care provider. We are committed to delivering the highest quality of treatments for successful care. **The following is a statement of our Financial Policy which is required for you to read and sign prior to any treatment. If you have any questions regarding this authorization, please do not hesitate to ask. We are here to serve you.**

DEDUCTABLE AND/OR CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.

Medicare/Medicaid/Patient Certification/Releases Information & Payment Request

I certify that the information given by me in applying for payment under title XVII and/or xix of the Social Security Act of 1972 is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and/or co-payments and that payment is due at the time services are rendered. I assign the benefits payable for physician or organization to submit a claim to Medicare/Medicaid for payment of services rendered for me.

Assignment of Insurance Benefits

I hereby authorize, request and direct any and all assigned insurance companies to pay directly to Bardmoor Cancer Center and/or any treating physician, the amount due me in my pending claims for the benefits under the respective policies. I agree that, should the amount be insufficient to cover the entire expense, I will be responsible for payment of the difference, and that if the nature of the disability be such that it is not covered by said policy depending upon insurance carrier, I will be responsible for payment of the entire bill.

Guarantee of Payment

For services rendered, the undersigned guarantees and promises to pay Bardmoor Cancer Center and/or any treating physician all charges and expenses incurred in the treatment, including those expenses not covered by any insurance policy presently in force, depending upon the contract between insurance carrier and Bardmoor Cancer Center.
Your Insurance policy is a contract between you and your insurance company. You may be asked to assist us in obtaining payment from your insurance carrier in the event they are not in compliance with State of Law of payment or denial within 30-45 days.
All secondary claim balances will become the patient's responsibility if payment is not received from the secondary carrier within 90 days from the date of services.

Unusual and Customary Rates

If we are not contracted with your insurance company, you will be responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates unless previous arrangements have been made.

I have read and fully understand this contract and have received a copy of it.

Patient's Signature _____ Date_____

BARDMOOR CANCER CENTER
FINANCIAL POLICY

As a courtesy to you, our patient, we will file your insurance for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your procedure is a non-covered benefit, accordingly to your insurance policy, it becomes an expense billable to you.

IT IS THE PATIENT'S RESPONSIBILTY to follow-up on any and all necessary referral authorizations **PRIOR TO YOUR VISIT** unless prior arrangements have been made with our Billing Department.

All co-payments are due at the time you sign in at the front desk and are payable by check, money order, cash, or credit card (Visa, MasterCard). If a check is returned by your bank for any reason, you will be charged a $30.00 Returned Check Fee, which will be added to your account, and must be paid in full either by cash or credit card prior to any further visits.

If you are a **SELF-PAY PATIENT** with no insurance coverage, 50% of all fees and services will be due prior to beginning treatment. The Billing Department can set up a payment plan for the balance if this is deemed financially necessary. All cases will be handled on an individual basis.

By signing below, I understand that **I AM ULTIMATLEY RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED** after all payments have been by the appropriate insurance carrier. If payment is not received in a timely manner, your account will be reviewed for further collection activities.

I ACKNOWLEDGE RECEIPT OF THIS FINANCIAL POLICY AND A COPY SHALL REMAIN IN MY CHART.

- RELEASE OF INFORMATION -

By signing below, I authorize Bardmoor Cancer Center to release any information with regard to my treatment, for insurance purposes. I also authorize Bardmoor Cancer Center to release my information to other physicians or institutions as necessary for my treatment.

I understand that any information giver with regard to my treatment shall remain CONFIDENTIAL and will be release only as necessary for my care and/or treatment.

Signature: _____ Date: _____