PONTCHARTRAIN
CANCER CENTER

Today's Date: _____

NEW PATIENT HISTORY FORM

Patient Name (PLEASE PRINT): _____

DOB: ____/____/____ Age: ____ □ Male □ Female Marital status: _____ SSN: _____

Home phone #: _____ Cell phone #: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? □ Yes □ No

Email Address: _____ May we email you? □ Yes □ No

Preferred Language:_____

Ethnicity/Race: □ White □ Hispanic/Latino □ Black/African American □ Native American

□ Asian/Pacific Islander □ Other

Pharmacy name: _____ Pharmacy phone # _____

Pharmacy address: _____ City: _____ Zip: _____

Employer: _____ Work #: _____

Emergency Contact: _____ Relationship: _____

Contact phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ RXBIN #:_____

Insured's name: _____ Insured's DOB: _____

SS#: _____ Relationship: _____ Employer: _____

Secondary Insurance: _____ Policy #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

Power of Attorney (if applicable): _____

Relation to You: _____

Living Will: □ Yes* □ No *If yes, please provide a copy for your records.

PATIENT RESPONSIBILITY AGREEMENT

By electing to receive health care services from Pontchartrain Cancer Center (PCC) and your signature on the Patient Responsibility Agreement, you agree to be bound by the below payment policies.

For All Patients:
It is your responsibility to be familiar with your benefit plan. If you are unsure whether services are covered, please call the telephone number located on the back of your insurance card before receiving services. If the services are not covered by your insurance plan, you will be billed for these services, and agree to pay PCC for the full amount.

PCC shall use and disclose your information, and will provide information to health insurers, programs, third party administrators, vendors, other providers, and health care facilities, as is allowed by federal and state laws and regulations. We may share your information to obtain payment, and to coordinate your care and treatment needs with other medical professionals as necessary. You authorize PCC to disclose all information as needed to ensure proper claims payment and care coordination.

Additionally, you acknowledge that diagnostic testing may be necessary as part of your care and treatment by PCC, and such tests may be performed by PCC using its owns diagnostic facilities and personnel, provided that, in some cases, diagnostic testing services and tests may be performed or provided by outside facilities. Further, in complex cases, a pathologist may request additional testing not initially ordered by your PCC oncologist, as necessary for diagnosis or in determining the correct treatment regimen. When outside diagnostic providers are used, you understand that you may receive a bill directly from the outside diagnostic provider.

Traditional Medicare Patients
If you are a patient with traditional Medicare only, you will be required to pay twenty percent (20%) of the approved Medicare rate at the time of service. PCC will bill Medicare for the remaining portion of your bill.

Traditional Medicare + Medicare Supplement
If you are a patient with traditional Medicare and a supplement plan, you will pay nothing at the time of service. PCC will bill both Medicare and your supplemental insurance plan. If there are services you've received that are not covered by either Medicare or your supplemental insurance, you will owe PCC for those services, and will be billed accordingly.

Traditional Medicare + Secondary Insurance
If you have Medicare and a secondary health plan, you will be responsible for payment of your deductibles and twenty percent (20%) of the approved Medicare rate, which is due at the time of service. PCC will bill both Medicare and your secondary policy. If the secondary insurer pays twenty percent (20%) of the approved Medicare rate, you will no longer be responsible for that portion at the time of service.

Commercial Insurance Patients (including Self-Insured Employer) and Medicare Replacement Patients
Payment of all copays, deductibles, and coinsurance are due at the time of service. PCC is contractually required by your insurance plan to charge you your share of the costs. You should

be familiar with your plan, including which services you receive require prior authorization from your insurer. Payment of your copays, deductibles and coinsurance is due at the time of service.

To Patients Visiting Louisiana From Other Locations

PCC has many contracts with insurers and networks so that services will be covered at the network rate for our patients, however, it would be impossible for PCC to contract with every insurance plan available. Prior to receiving services at PCC, it is your responsibility to make sure that services are covered in Louisiana. Some plans have travel benefits that must be activated by the patient prior to receiving services, and some plans have out of network benefits that will cover services, but at a higher out-of-pocket cost to patients.

Some plans, in particular HMO plans, do not have any benefits in Louisiana at all except for emergency services. Call the number on the back of your card and verify that you are able to receive care in Louisiana from PCC.

Out of Network Patients

As noted above, PCC has extensive contracts with various health insurers, but not all. If you elect to receive services at PCC and PCC is not contracted with your insurance carrier, PCC is considered out of network. If you have out of network benefits, PCC will bill and collect from your insurance company in most, but not all cases. By electing to receive services from an out of network physician, you acknowledge that you are responsible for the payments as dictated by your plan benefits for receiving services from an out of network physician.

Some plans, most notable HMO plans, do not have out of network benefits. If PCC is not participating with your insurance company, PCC will not be able to bill and receive payment for services rendered to you. You should seek care from a physician that is contracted with your insurer.

For All Patients

PCC will verify your coverage and benefits, and submit your claims to your insurer for payment. You agree to assign your right to receive payment to PCC, and PCC will receive payment directly from your insurer. This does not waive your obligation to pay all copays, deductibles, and coinsurance per your plan benefits.

PCC accepts cash, check, and most major credit cards. If you are unsure of how much to pay, there are Financial Counselors available at each location to assist with insurance questions. If you have any questions, please contact the Financial Counselor at your location or our central billing office at (985) 419-0025.

At Pontchartrain Cancer Center, our passion is to provide you with the most advanced cancer treatment in a home town, community setting. Our business is our patients, and we appreciate you. Thank you in advance for adhering to our payment policies.

Patient Signature _____ **Date:** _____

Parent Signature or P.O.A. _____ **Date**: _____