CANCER & BLOOD DISORDERS TREATMENT CENTER

Ph: 301-396-9215
Ans. Service: 301-645-0288
Fax: 301-638-1009

PATIENT REGISTRATION

• *Please Print Clearly*

PATIENT NAME First	Middle	Last		DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO	CITY	STATE	ZIP CODE	
OCCUPATION EMPLOYED ☐ RETIRED ☐ STUDENT: ☐FT ☐PT	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE	
EMPLOYER (or previous employer, if retired)	ADDRESS			WORK PHONE	
SPOUSE (or Parent) NAME	SPOUSE (or Parent) EMPLOYER			SPOUSE (or Parent) WORK PHONE	
SPOUSE (or Parent) ADDRESS					
NEAREST RELATIVE/FRIEND	RELATIONSHIP	HOME PHONE		WORK PHONE	
RELATIVE/FRIEND ADDRESS					
REFERRING PHYSICIAN	ADDRESS			TELEPHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

It is our policy that we will file all claims to those insurance companies in which we are a participating provider. You are responsible for all co-payments and deductibles at the time of service. If we do not participate with your insurance plan, payment is expected at the time of service. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, money order, checks and Visa/MasterCard.

If my account becomes assigned to a collection agency, I agree to pay the 25% collection agency fees associated with my account balance. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

x _____

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT'S AUTHORIZATION

I, _____, hereby authorize **CANCER & BLOOD DISORDERS TREATMENT CENTER**, to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capitol Area, Blue Shield of Maryland, Medicare, and/or _____.

(Name of Other Insurance Company)

I certify that the information I have reported with regards to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the caseof Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

_____ Signature of Subscriber or Beneficiary

_____ Date