BHAGWAT PATEL M.D., P.A.

1250 Creekway Drive Suite #100
Sugar Land, TX 77478
(281) 494-1420

NEW PATIENT INFORMATION FORM

Welcome to our office, please complete this form and return it to the receptionist so that we can most effectively meet your needs.

Patients Name: _____ **Date:** _____
Last First Middle

Mailing Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone #** _____ **Hm.** **Cell #** _____

Referring Physician: _____ **Social Security No.:** _____

Patient Sex: MALE FEMALE Birth Date: _____ **Age:** _____ **Marital Status: S M W D**

Race: _____ **Ethnicity:** _____ **Language:** _____

Preferred Pharmacy Name/Phone: _____

Occupation: _____ **Employer:** _____

Work Phone: _____ **Spouse:** _____

Emergency Contact Name: _____ **PH#.** _____

PAYMENT RESPONSIBILITY:

Are you personally responsible for the payment of your fees: YES NO If no, who is?
Responsible Person: _____ **SS#:** _____ **DOB:** _____
Guarantor'semployer: _____ **Phone #** _____

INSURANCE : (PLEASE LIST ALL THAT APPLY FOR PROPER BILLING)

NAME OF INSURED: _____ **DOB:** _____

PRIMARY:

INS. Name: _____
INS. ID# _____
Group#: _____
Effective Date: _____
Copay/Co-Ins: _____

SECONDARY:

INS. Name: _____
INS. ID#: _____
Group#: _____
Effective Date: _____
Copay/Co-Ins: _____

Authorization for Treatment:

I authorize Dr. Bhagwat Patel, M.D. to evaluate, diagnose, treat and perform medical and/or surgical procedures as he deem necessary for the treatment of my underlying condition.

I authorize the release of any medical information necessary to process Medicare or insurance claims and authorize payment directly to BHAGWAT PATEL M.D., P.A. of Medicare benefits or medical and surgical benefits of my insurance policy(s).

Patient's Signature: _____ **Date :** _____

BHAGWAT PATEL M.D., P.A.
FINANCIAL POLICY AND HIPPA CONSENT

WELCOME:

We are committed to providing you with quality medical care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or responsibility.

To assist us in establishing your account please (1) provide current insurance information at the time of service and (2) authorize release of information necessary for insurance filing and precertification (sign on the line below). Failure to do so will affect your financial responsibility for charges incurred. Your payment can be in the form of cash, check, or credit card.

REGARDING INSURANCE:

***Co-Pays, Co-ins or Deductibles are due at the time of service.** **Contracted Manage Healthcare Plans (HMO, PPO, POS, EPO, MC.)** **Each time you make an appointment it is your responsibility to make sure this office is currently under contract with your plan and you have obtained the necessary referrals.** **Verification of your plan is required. Often this verification requires us to share the reason of your visit with your managed care plan. Please plan to show your current card to our staff upon request. Co-Payment, Co- Insurance, deductible and/ or fees for non covered services are required at the time of service.**

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company, regarding deductibles, non-covered/ covered charges, co-insurance, secondary co-insurance, and coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for the timely payment of your account. **Many services performed in our office may be covered by your insurance, but may be subject to deductible or co-insurance. Any deductible, co-insurance, or non-covered service is your responsibility to pay, and we may ask for payment at the time of service.**

CONSENT TO USE AND DISCLOSE PROTECTED PATIENT HEALTH INFORMATION ACKNOWLEDGMENT.

Notice of Privacy Policies and Procedures:

Our "Notice of Privacy Policies Procedures" provides information about how we may use and disclose protected health information (PHI) about you. As stated in our "Notice of Privacy Policies" for a more completed description of how your protected information may be used or disclosed.

I acknowledge I have noticed BHAGWAT PATEL M.D., P.A.'S Notice of Privacy Practices posted on the wall. I have read and understand the above terms and conditions and will verify so by giving my signature.
I agree to release any and all medical information, including test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits.

Patient/ Responsible Party: _____Relationship _____

Signature of Patient/ Responsible Party: _____Date: _____