OFFICE REGISTRATION FORM

Please **PRINT** and complete all sections below.

Today's Date_____

Last Name: _____ First: _____ MI: _____ Marital Status: S M W D Sep

Date of Birth: _____ Age: _____ M or F Social Security #_____

Street Address: _____ City, State, Zip: _____

Phone (day):_____ Phone Cell: _____

Email Address: _____

In Case of Emergency:
Emergency Contact: _____ Relationship to patient_____

Phone: _____ Cell: _____

Insurance Information:

_____Medicare _____Medicaid _____HMO _____PPO _____ Self Pay Copay amount_____

PLEASE NOTE IF YOU HAVE A HMO PLAN YOU WILL NEED AUTHORIZATION

Primary Care physician:

Name: _____ **Phone:** _____ **Fax:** _____

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

Pharmacy Information:

Local Pharmacy Name: _____ Phone: _____ Fax:_____

Address: _____ City: _____ State: _____ Zip: _____

Mail Order Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment information:

Employer _____ Occupation: _____

Address: _____ City, state, Zip: _____

Phone _____

Financial Policy

We are pleased to have you as our patient and we are committed to providing you with the best professional care. Your clear understanding of our financial policy is important to our relationship.

Payments

If you have no insurance, we require payment in full at the time of service and will be accepted by Cash or Card ONLY. All co-pays are due the day of appointment. If you're insurance requires you to pay a co-pay please know this is due every time you are seen at office. If you do not have your co-pay at your appointment it will be rescheduled

We will accept Cash, Visa, Mater Card, Discover and Checks are accepted.

Participating Provider Plans/HMO Plans

We will file claims for patient's whose insurance companies are contracted with us. However, co-pays are due at the time of appointment and for each appointment. Due to all the various HMO and PPO insurance plans now in effect it is a complicated process to remain familiar with every one. We require that all patients seek out all information for providing this information to our office. It is the patient's responsibility to make sure that their primary issue an authorization (for HMO) for each visit.

Commercial and Private Insurance

It is our office policy to bill your insurance carrier as a courtesy to you. You are ultimately responsible to see that the account is paid in full. In order for our office to bill your insurance carrier, you will need to supply our office with all the requested information and current co-pay of your insurance card. Your insurance policy is an agreement between you and your insurance company. You are responsible for all the charges.

Medicare

We are Medicare providers and do accept assignment from Medicare. There may be a balance due from patient after Medicare pays. If you have a secondary insurance, we will submit this for you. You will receive a statement showing any balance due by you.

Medical Assistance or Medicaid

Special procedures are necessary for handling these claims. All patients must show a valid card each time before seeing a doctor. We will also verify eligibility prior to you being seen by the doctor. If ineligible or **you did not provide us with an ID card, your appointment will be rescheduled, as we are required to verify current coverage.**

Collections

We accept Cash, Check, Visa, MasterCard and Discover. If you need to make a payment arrangement due to financial hardship, our business office requires patients to call to make mutually satisfactory arrangements prior to you scheduled appointment.

You must be able to show Insurance Card and a Government ID at time of appointment.

I have read and I understand the above policy.

Print Name: _____ **Signature:** _____

Relationship (If other than patient signing)_____ **Date:**_____

HHQ(history)

Have any of the following caused you concern lately: (Please circle)

Decreased Appetite	Black, Tarry stool	Joint Pain
Weight Loss	Rectal bleeding	Paralysis
Anemia (low blood)	Diarrhea	Blood in urine
Nausea/Vomiting	Constipation	Rash
Heartburn	Change in size or	Fever
Difficulty swallowing	Shape of stool	Chills
Food sticking	Hallucinations	Vision changes
Gas	Deafness	Nosebleeds
Abdominal pain	Earache	Coughing blood

If Yes, please explain: _____

_____

_____

Medications (please list all and/or provide list): _____

_____

_____

Allergies: _____

Past Medical History:

Have you had any of the following past or present (please circle)

High blood pressure	Kidney disease	Colon Polyps
Heart disease	Pancreatic disease	Ulcerative Colitis
Heart attack	Diabetes	Crohn's disease
Emphysema	Gall stones	Hepatitis/Liver disease
Asthma	Cancer (where_____)	Stomach ulcers
Stroke/CVA	Chemotherapy	Diverticulosis
COPD	Radiation	Diverticulitis
Thyroid disease	GERD/Acid reflux	IBS
Anemia		Hemorrhoids
Arthritis		Hernia

Past Surgical History:

Have you had any of the following (please circle)

Peptic ulcer surgery	Colon surgery	Hemorrhoidectomy
Hysterectomy	Gallbladder surgery	Appendectomy
Colonoscopy	Gastroscopy/EGD	Coronary Bypass/CABG
Aortic aneurysm surgery	Cancer (which organ _____)	
Pacemaker	Defribilator/AICD	

Any other surgery? Please list all _____

_____

Family History:

Please indicate if your grandparents, parents, brothers, sisters, and/or children have had the following conditions. Please list who had in the space provided.

High blood pressure _____ Heart disease _____

Diabetes _____ Colon polyps _____

Cancer (where?) _____

Social History:

Please indicate if you currently use or have used the following and how much:

Tobacco No_____ PPD _____ Ex-smoker _____

Alcohol No_____ Per Day: Beer _____ Wine _____ Other _____

PATIENT NAME AND DOB_____ **DATE:**_____

Satish Patel, M.D., P.A.
5340 Gulf Dr, Ste 105
New Port Richey, FL 34652
Tel: (727) 849-0222 | Fax: (727) 847-7685

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA OMNIBUS RULE NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Satish Patel, M.D., P.A. A copy of this signed and dated document shall be as effective as the original.

Printed Name of Patient	Date of Birth
Printed Name of Legal Representative *(if applicable)*	Relationship to Patient
Signature of Patient *or* Legal Representative	Date Signed

. . . . . .

HIPAA

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's (or legal representative's) signature on this Acknowledgement, but did not do so because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient.
- ☐ The patient refused to sign.
- ☐ The patient was unable to sign because _____.
- ☐ Other *(specify)*: _____.

Employee Name: _____ Signature: _____

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Satish Patel, M.D., P.A. to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Signature of Patient/Legal Representative Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received/reviewed a copy of Satish Patel, M.D., P.A.'s Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

OFFICE USE ONLY		
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so for the reason documents below:		
Date	**Initials**	**Reason**

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Satish Patel, M.D., P.A. to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Satish Patel, M.D., P.A. for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative Date

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT SELF-DETERMINATION QUESTIONNAIRE
YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures
  - ☐ I have made a Living Will
  - ☐ I do NOT have a Living Will
- Health Care Surrogate
  - ☐ I have designated a Health Care Surrogate
  - ☐ I have NOT designated a Health Care Surrogate
- Durable Power of Attorney
  - ☐ I have appointed a Durable Power of Attorney for Health Care Decisions
  - ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have a living will and/or an assigned health care surrogate we will gladly make a copy of your documents and place it in your chart.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL": ☐ Check here to indicate that this statement was read.

IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ **Yes** ☐ **No**

V. Please print the phone number where you want to receive calls about your appointments _____

☐ I am fully aware that a cell phone is not a secure and private line.

PATIENT/GUARDIAN/POA PLEASE SIGN **DATE**