Patient Information

Date:_____

Patient Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age_____ Sex:_____M _____F Social Security #:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Marital Status:_____S_____M_____W_____D Spouse Name:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Patient Employer:_____ Phone #:_____

Employer address:_____
Street City, State, Zip

Referring Physician:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

Mother Maiden Name:_____

PRIMARY INSURANCE

Ins. Co. Name:_____ Phone #:_____

Claims Address:_____
Street or PO Box City State Zip

Employer Name:_____ Group #:_____ Subscriber ID#_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Patient relationship to insured: ____self ____spouse ____child ____other

SECONDARY INSURSANCE

Ins. Co. Name:_____ Phone #:_____

Claims Address:_____
Street or PO Box City State Zip

Employer Name:_____ Group #:_____ Subscriber ID#_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Patient relationship to insured: ____self ____spouse ____child ____other

Pharmacy Name and Phone #:_____

Medical History Questionnaire

Date:_____

Last Name:	First Name:	MI:	Date of Birth:	Age:
Referring Doctor:			Height:	Weight:

List Current Problem

Current Medications (including weight reduction meds)	Drug Allergies (include Reaction)

Past Medical Diagnosis (circle Y=yes M= taking medication N=not diagnosed)											
Diabetes	Y	M	N	Reflux	Y	M	N	Glaucoma	Y	M	N
Heart Attack	Y	M	N	Arthritis	Y	M	N	Asthma	Y	M	N
Stroke	Y	M	N	AIDS	Y	M	N	Emphysema	Y	M	N
Angina/chest pain	Y	M	N	HIV infection	Y	M	N	Ulcers	Y	M	N
High blood pressure	Y	M	N	Kidney failure	Y	M	N	Cancer	Y	M	N
Heart Failure	Y	M	N	Thyroid problem	Y	M	N	If yes, type & location of cancer			
Hepatitis	Y	M	N	Colitis	Y	M	N				
Jaundice (yellow skin)	Y	M	N	Sleep apnea	Y	M	N				
Bleeding problems	Y	M	N	High Cholesterol	Y	M	N	Other:			

Previous Surgeries	Year	Comments (to be completed by physician
Problems with anesthesia? ____yes ____no Explain:		

Tobacco Use (circle)		Alcohol Consumption (circle)		Substance Abuse (circle)			
1	No	1	No	1	None	4	Heroin
2	Cigarettes ____Packs per day	2	Yes ____drinks per week	2	Marijuana	5	Other
3	Smokeless			3	Cocaine		

Family Medical History (circle)		Family History of (circle)- Relationship to you						
1	Both parents living and well	Heart Attack	Y	N	Bleeding	Y	N	
2	One parent deceased, caused by:	Diabetes	Y	N	Anesthesia problems	Y	N	
		Breast Cancer	Y	N				
3	Both parents deceased, caused by:	Ovarian Cancer	Y	N				
	Mother:	Lung Cancer	Y	N				
	Father:	Colon Cancer	Y	N				

Houston Internal Medicine Associates, P.A.

Name:_____ Date of Birth:_____

Please provide the names, phone number and fax number of any other physician/specialist you see, so we may contact them if necessary to give you with best treatment possible.

Physician/Specialist

Physician/Specialist Name	Phone Number	Fax Number

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I herby authorize Houston Internal Medicine Associates, PA ("the practice") to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize to Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

_____ _____

Patient Signature *Date*

_____ _____

Printed Name *Date of Birth*

I understand that I am entitled to a copy of a "Notice of Privacy Practices".

_____ _____

Signature *Date*

NOTICE OF PRIVACY ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth:_____

Social Security Number:_____

I acknowledge that provided HOUSTON INTERNAL MEDICINE ASSOCIATES, P.A. provided Me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

CONDITIONS OF SERVICES

PATIENT _____ DATE_____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Houston Internal Medicine Associates, P.A. (clinic) to release patient healthcare Information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to the practice for services rendered.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by the practice, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

X_____ _____

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I hereby authorize the clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail, or electronic submission.

X_____ _____

Patient/Guarantor Signature Date

Do you have an advanced directive (living will)? _____Yes _____No

If yes, please bring a copy into our office for our files.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discus your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____I do not authorize the Practice to release any or all information concerning my Medical care to any individual except as set forth above.

____I authorize the Practice to verbally release any or all information concerning my Medical care to the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Patient Signature	Date

HOUSTON INTERNAL MEDICINE ASSOCIATES. PA

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Houston Internal Medicine Associates, P.A.
21336 Provincial Blvd. Katy, TX 77450
Phone: 281-809-0085
Fax: 281-809-0083

Request For Release of Medical Records

Date:_____

Patient Name:_____ DOB:_____

Address:_____

_____

Phone:_____ SS#_____

I hereby request my medical records to be release to:

Dr. Vijayshekar Elati, M.D./Lakshmi Reddy, M.D.

From:_____

Physician Name:_____

Address:_____

_____

Phone:_____ Fax:_____

Dates Requested:_____

Patient's Signature:_____