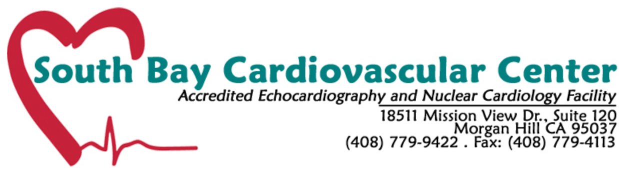

Anu Chirala M.D., F.A.C.C
Board Certified in Cardiovascular Diseases
& Nuclear Cardiology
www.SouthBayCardiovascularCenter.com

New Patient Information

* Required Information

Name* ______________________________ Soc. Sec #* ______________
Last   Middle Initial   First

Date of Birth* ______________ Gender*: ____ Marital Status* ____________
mm / dd / yyyy   M / F   Married / Single / Widowed / Divorced

Address* ________________________________ State* ____ Zip* ________

Phone*: Home ____________ Cell _____________ Work ______________

Email _____________________ Primary care doctor* Dr. _______________

Local Pharmacy* ______________ Mail Order Pharmacy ________________

Primary Insurance

[Please submit All Insurance Cards and Drivers License or other picture ID when asked]

Insurance* _____________________ Subscriber ID* __________________

Subscriber Name* _______________________ Date of birth* ___________

Social sec#* ____________ Relationship to patient* ___________________

Secondary Insurance

Insurance _______________________ Subscriber ID __________________

Subscriber Name _______________________ Date of birth _____________

Social sec# ____________ Relationship to patient ____________________

South Bay Cardiovascular Center
Accredited Echocardiography and Nuclear Cardiology Facility
18511 Mission View Dr., Suite 120
Morgan Hill CA 95037
(408) 779-9422 . Fax: (408) 779-4113

ICANL Nuclear Cardiology Accredited Nuclear Cardiology Laboratory
ICAEL Accredited Echocardiography Laboratory

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM [Required Information]

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name________________________________ Date of birth______________

Signature_____________________________ Date____________________

- -

EMERGENCY CONTACT INFO [Required Information]

Name________________________________ Phone/Cell __________________

Relationship____

- -

PATIENT FAMILY/FRIEND DISCLOSURES

Please indicate to whom we can disclose your medical information/condition with:

Name_______________________ Name____________________

Relationship__________________ Relationship_______________

Telephone____________________ Telephone_________________

- -

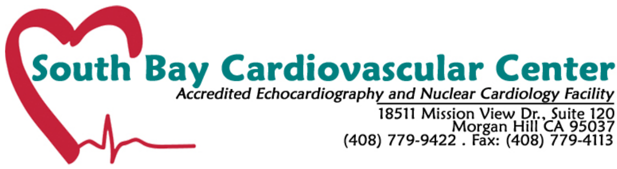
REQUEST TO CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about your medical matter in a certain way or certain location.

Contact me at: Home _____________Work_____________Cell_______________

( ) Ok to leave message with detailed information.

( ) Leave message with call-back number only.



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ASSIGNMENT AND RELEASE

I, ________________________________, certify that I (or my dependent) have insurance

coverage with ____
[List Name of Insurance Company(ies)]

and assign directly to Anu Chirala, A Medical Corporation (dba. South Bay Cardiovascular Center) all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________	______________________	__________
Responsible Party Signature	**Relationship**	**Date**

We accept Medicare assignment. If you have insurance, no payment is due other than your co-pay which is due at the time of service. As a courtesy, we will bill your primary insurance with the understanding that ANY payment will be directed to OUR office. We will also bill secondary insurance as a courtesy, but we will only bill once, and if billing is delayed, balance will be transferred to the patient (or responsible party). If insurance payment is delayed 60 days, we will bill YOU directly for ALL unpaid services. You are ultimately responsible for your account.

If your insurance plan requires pre-authorization or restricted benefits apply regarding choice of laboratory, x-ray facility, hospital, office visit(s) or diagnostic testing whether done in office or outside facility, as a courtesy the office staff will try to obtain authorizations for these services, but it is ultimately the patients responsibility to be sure that this is completed. It is ultimately your responsibility to go to the correct facility for labs, x-rays and hospitalization. Clerical fees may be charged for completion of special insurance forms.

Please inform our office, if you have difficulty settling your account. There will be a $50 processing fee on ALL returned checks.

Past due accounts are subject to collection action. Legal fees involved in any collection action are the sole responsibility of the patient (or responsible party). It is your responsibility to notify our office promptly of any changes in name, address, telephone numbers or insurance coverage.

I have read, understand and agree to the above office policy.,

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

________________________________	______________________
Signature	**Date**