Notice of Privacy

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To Correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. **Communications:** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by your agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

   You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Sushma Bhadauria, M.D. at 6310 San Vicente Blvd. Suite #290, Los Angeles, Ca 90048 Tel. (323) 525-0740 Fax. (877) 531-6921.**

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice to request amendment, your request must be made in writing and submitted to **Sushma Bhadauria, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 525-0740 Fax: (877) 531-6921**. You must provide us with a reason that supports your request for Amendment.

5. Right to file a complaint: If you believe your rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Sushma Bhadauria, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 525-0740 Fax: (877) 531-6921**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Sushma Bhadauria, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 525-0740 Fax: (877) 531-6921.**

Sushma Bhadauria, M.D.
Obstetrics and Gynecology
6330 San Vicente Blvd Suite # 300
Los Angeles, CA 90048
Phone: (323) 525-0740 Fax: (877) 531-6921

I hereby acknowledge that I have been given a copy of Sushma Bhadauria, M.D. Notice of Privacy Practices.

Name of Patient:_____**Date:** _____

Signature: _____

Sushma Bhadauria, M.D.
Obstetrics, Gynecology and Infertility
6330 San Vicente Blvd Suite # 300
Los Angeles, CA 90048
Phone: (323) 525-0740 Fax: (877) 531-6921

REGISTRATION FORM

Today's date: Referring Physician:(if applicable)

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

E-mail address: PRIMARY CARE PHYSICIAN Name & Phone number: Social Security number: Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Cell phone number: ( ) Home phone number: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

How do you prefer to receive your statements (please check one box): ❑ Fax ❑ E-Mail ❑ Mail

Who may we thank for your referral?

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY

Name of local relative or friend: Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Bhadauria. I understand that I am financially responsible to check my insurance benefits; and in-network status. I am responsible to verify that my insurance will cover any visit including preventative services and within the allowed timeframe (example: annual visit are covered only once within 12 months from last annual visit).

I also understand that if I do not provide insurance information, full payment is due at the time of service. If there are situations when making a payment can be a financial hardship, special payments can be arranged with prior notice to my visit. If a cancellation of my visit is required I must give the office of Dr. Sushma Bhadauria a 24 hour notice to accommodate other patients seeking appointments and I am aware that if I do not cancel in advance I will be subject to a fee of $45.

There are some services that are offered by Dr. Sushma Bhadauria that may not be covered by insurance, not considered medically necessary or reimbursed far below the cost of product and will be my full responsibility; as my physician considers these necessary for treatment or suggested to me for convince. There may be other non-covered services that will be my full responsibility for example completion of forms, request for medical records, contraception, infertility, and some vaccines. In the event I am responsible for my surgery and or delivery, I am required to put a deposit that will be determined by the following; policy copay, deductible and co-insurance.

I also, understand that the cost of laboratory testing is not included in the bill I will receive from the doctor and will be responsible to find out whether the labs and or referrals are in-network. If Dr. Bhadauria's office has checked benefits, this doesn't ensure guarantee of payment. I understand that I am financially responsible for all balances that are not paid by my insurance company. I also authorize Sushma Bhadauria, M.D or my insurance company to release any information required to process my claims. Should collections proceedings or other legal actions become necessary to collect an overdue account, it will be my responsibility or the responsible third party to understand that there's a right to disclose an outside collection agency and any terms this agency may have. The responsible party will also be liable to interest, all court cost, attorney fees, and all collection fees will be added to the outstanding balance.

Patient and/ or Guardian signature *Date*

Sushma Bhadauria, M.D.
6330 San Vicente Blvd. Suite # 300
Los Angeles, CA 90048
Phone: (323) 525-0740 Fax: (877) 531-6921

Patient Record of Disclosures

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Work Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Cellular Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Written Communication

- ☐ *Ok to mail to my home address*
- ☐ *Ok to mail to my work/office address*
- ☐ *Ok to fax to this to this number* _____

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, please list the names of these individuals here:

_____
_____
_____
_____

Other Instructions:

_____
_____
_____
_____

Patient Name: _____ ***Date:*** _____

Signature: _____ ***Date of Birth:*** _____

Sushma Bhadauria, M.D.
6330 San Vicente Blvd. #300
Los Angeles, CA 90048
T: (323) 525-0740

*Financial Policy for*_____

PATIENT RESPONSIBILITY AGREEMENT
I understand that it is my responsibility to contact my insurance carrier prior to an appointment or procedure should I wish to verify what my policy will and will not cover.

ADDITIONAL CHARGES
Completion of Forms may be subject to an additional charge.

AGREEMENT TO PAYMENT POLICY
I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION
I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

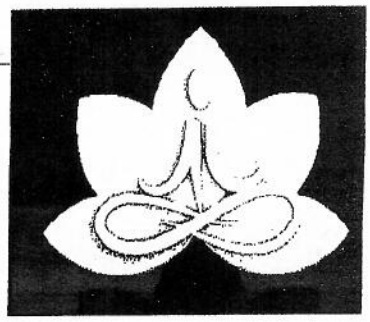
ASSIGNMENT OF BENEFITS
I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Sushma Bhadauria, M.D. for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT
If my insurance has a contract with Sushma Bhadauria, M.D, I am not responsible for amounts she has agreed to write-off per the contract. If my insurance does not have a contract with Sushma Bhadauria, M.D, I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES
I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Sushma Bhadauria, M.D.

Patient's Name Printed	Patient's Date of Birth
Patient's Signature	Date
Responsible Party Signature	Relationship to Patient

Sushma Bhadauria, M.D
Obstetrics, Gynecology & Infertility
6330 San Vicente Blvd
Suite #300
Los Angeles, CA 90048
(PH) 323-525-0740 (F) 877-531-6921



IMPORTANT PATIENT NOTICE

Please be advised: It is very important that you get acquainted with your particular insurance plan and the financial responsibility you will incur during the course of your visit. To assist you, we have complied a few common terms and lab information.

Copayment: A copayment or copay is a payment defined by your particular insurance policy and paid by the insured person (the patient) each time a medical service is provided. It is usually a set dollar amount for a specialist and can be often found on your insurance card.

Deductible: A deductible is the amount you pay out of your own pocket before your insurance begins paying the health care cost. Once the deductible is met in full, the insurance will pay the rest of the amount due on your claim (minus your copay and co-insurance).

Co-insurance: A coinsurance is a shared cost that you and your insurance will pay on a claim after your deductible has been met. The health insurance company will pay a certain percentage of your health care bills, while you pay the remaining percentage.

Lab Information:

The cost of laboratory testing is not included in the bill you receive from your doctor. Depending on whether you have health insurance and the terms of your coverage, you may be responsible for some or all the cost of your laboratory testing. **It is the responsibility of the patient to find out whether the labs and or referrals are In-Network.**

For any further questions, we encourage you to call the customer service number on the back of your insurance card.

I have read and understand the information provided and further understand that the fees for the lab are my responsibility and I agree to pay. I release the Medical physician and all staff from any and all cost, liability resulting directly or indirectly.

_____ _____

Signature of Patient Date of Service

Telephone Consent Form

Please check an option

I, _____, hereby

(Print patients first and last name)

☐ Consent and staff to able to call via telephone and leave a detailed message/voicemail with my **results** at the following number (s):

☐ Consent to communicate with me (when applicable) via **Video Conferencing (doxy.me)** to follow up regarding my health and any ongoing treatment.

(_____) _____ Does this number accept blocked/private calls? ☐ **Yes** ☐ **No**

E-mail Address (if applicable): _____

☐ Decline. Please do not leave messages.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the appendix to this consent form, associated with the use of the services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism of electronic communications, it is possible that communications with the Physician and Physician staff using the services may not be encrypted.

Despite this, I agree to communicate with the Physician or Physician's staff using the services with a full understating of the risk. I acknowledge that either the physician or I may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

I have reviewed and understand all of the risks, conditions and instructions described in this appendix.

Signature:_____ Date: _____