PANDYA MEDICAL CENTER

PATIENT INFORMATION FORM

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING A PROVIDER

LAST NAME _____ FIRST NAME _____ M.I. ___

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE (H) _____ (W) _____

(C): _____ EMAIL ADDRESS _____

SSN ___ - __ - ___ BIRTHDATE _____ SEX (M) ___ (F) ___ MARITAL STATUS: S M W D

ETHNICITY (please circle): African Am. Asian Caucasian/White Hispanic Indian/South Asian Native American Other____ Refuse_____

EMERGENCY CONTACT NAME _____ PHONE _____ Relationship _____

INSURANCE CARRIER _____ INSURED'S SSN ___ - ____ - ___

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT _____

INSURED'S BIRTHDATE: ____/____/____ INSURED'SEMPLOYER _____

EMPLOYER'S ADDRESS _____

SECONDARY INSURANCE CARRIER _____ INSURED'S SSN ___ - ___ - ____

INSURED'S NAME _____ INSURED'S BIRTHDATE ____/____/____

PHARMACY INFORMATION: NAME: _____

ADDRESS: _____

_____

PHONE: _____

IF A PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

FATHER'S NAME _____ PHONE _____

MOTHER'S NAME _____ PHONE _____

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO PANDYA MEDICAL CENTER TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS OR MEDICAL FACILITIES ASSOCIATED WITH MY CARE PLAN. I UNDERSTAND THAT PANDYA MEDICAL CENTER ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENT TO THE VISIT AND MY HEALTH WILL BE RELEASED.

SIGNED _____ **DATE:** ____/____/____

3925-A Johns Creek Court, Suwanee, GA 30024
3970 Deputy Bill Cantrell Memorial Rd, #220, Cumming, GA 30040

Phone: 770-709-6922
Fax: 770-709-6910

PANDYA MEDICAL CENTER

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check in at the front desk and present your **current insurance card at every visit**. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.
2. We require a credit card on file for all patients (**Please see the Credit Card on File Policy**)
3. It is your responsibility to inform your insurance company that we are your primary care physicians as of this date. If this is not done, you may be financially responsible for the visit.
4. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances. These payments are due at time of service.
5. Co-payments are due at time of service. A **$10 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid in full at time of service.
6. We file claims as a courtesy. If claims are unpaid after 90 days, they will be referred to a collection agency. Please be sure to follow up with your insurance company regarding claim status. You are responsible for any balance on your account.
7. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if a pre-authorization is required prior to a procedure, and which services are covered.
8. Not all services provided by our office are covered by every insurance plan. Any service determined to not be covered by your insurance plan will be your financial responsibility.
9. If our physicians do not participate in your insurance plan or if you do not have health insurance, payment in full is expected from you at the time of your office visit. Payment plans are available on a case by case basis, please speak with our staff for further information.
10. Any and all patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
11. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days may be charged a $10 re-bill fee. Any balance over 90 days will be forwarded to a collection agency.
12. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. (**Please see the Credit Card on File Policy**)
13. For scheduled appointments, prior balances must be paid prior to the visit.
14. We require either 24hr to 48hr notice for canceling appointments, depending on the type of the appointment. Failure to do so may result in a charge to your account, depending on the type of the appointment. The notice requirements and the fees are as following:
    a) Office visit – less than 24hour notice - $25 fee b) Ultrasound visit – less than 48hr notice - $45 fee
    c) IV Infusion visit – less than 48hr notice - $75 fee d) Nuclear Stress Test visit – less than 48hr notice - $200 fee.
    e) Nutritionist Visit – less than 24hr notice - $25 fee.
15. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred by us.
16. If you or your child have school, camp, or sport forms to be completed, there is a **$25** charge per form. Payment is due when the forms are dropped off. If you or your child have not had a physical or been seen in 1 year in our clinic, then you will be required to make an office visit to be seen so accurate health information can be collected and filled in the respective forms.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____
Responsible Party Name & Signature

_____/_____/_____
Date

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PANDYA MEDICAL CENTER

Authorization for Treatment and Assignment of Benefits

I authorize to receive treatment by Pandya Medical Center and its staff for the person named on this form. I authorize all insurance benefits to be paid directly to Pandya Medical Center.

_____ ____/____/____

Name & Signature of Patient or Responsible Party Date

Release of Billing Information

I give my permission for Pandya Medical Center to bill my health insurance company for services provided to the named individual listed on this form. I agree and acknowledge that my signature on this document authorizes Pandya Medical Center to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ ____/____/____

Name & Signature of Patient or Responsible Party Date

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PANDYA MEDICAL CENTER

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please do not hesitate to ask.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object: required by law, public health reasons, communicable diseases, required by the FDA, abuse or neglect of a patient, workers' compensation, inmates under treatment.

2. Your Rights

You have the right to inspect and copy your protected health information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
You have the right to request a restriction of your protected health information and ask us not to disclose your information to certain individuals.
You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests.
You may have the right to have your physician amend your protected health information if you believe it is incomplete or inaccurate.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

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PANDYA MEDICAL CENTER

I authorize the following **to have access** to my Protected Health Information:

Print Name	Relationship	Date
Print Name	Relationship	Date
Print Name	Relationship	Date

I give my permission for Pandya Medical Center and its staff **to leave messages/communications** about my health, medical results, lab results or appointment on the following numbers:

HOME: _____

MOBILE/CELL: _____

WORK: _____

Receipt of Notice of Privacy Practices
Written Acknowledgement

I, _____ have received a copy of Notice of Privacy from Pandya Medical Center.

Signature of Patient or Guardian: _____ **Date:**____/____/____

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