

## 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.

**Sushma Bhaduria, M.D.**

**Obstetrics and Gynecology**

6310 San Vicente Blvd Suite # 290

Los Angeles, Ca 90048

Phone: (323) 525-0740 Fax: (877) 531-6921

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

**Signature:** \_\_\_\_\_ **Date.** \_\_\_\_\_

**Name of Patient:** \_\_\_\_\_

# Sushma Bhadauria, M.D.

**Obstetrics, Gynecology and Infertility**

6310 San Vicente Blvd Suite # 290

Los Angeles, Ca 90048

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## REGISTRATION FORM

Today's date:		Referring Physician:( if applicable)			
<b>PATIENT INFORMATION</b>					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Fax	<input type="checkbox"/> E-Mail <input type="checkbox"/> Mail
Who may we thank for your referral?					
<b>INSURANCE INFORMATION</b>					
Please give your insurance card to the receptionist.					
<b>IN CASE OF EMERGENCY</b>					
Name of local relative or friend:		Relationship to patient:	Home phone no.:	Work phone no.:	
			( )	( )	
<p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p>					
Patient and/ or Guardian signature			Date		

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**6310 San Vicente Blvd. Suite # 290**  
**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 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_

**Sushma Bhadauria, M.D.**

6310 San Vicente Blvd. #290

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