SAHAI SURGICAL
GENERAL COLORECTAL ONCOLOGY

Aalok K. Sahai, M.D. Rohit K. Sahai, M.D. Irina Bernescu, M.D.

PATIENT INFORMATION FORM

DATE _____ { } MARRIED { } SINGLE { } SEPARATED { } DIVORCED { } PARTNERED

PATIENT LAST NAME _____ **FIRST NAME** _____ **MI** _____ SEX (PLEASE CIRCLE) M / F

AGE _____ DATE OF BIRTH _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ PHONE _____ OCCUPATION _____

SPOUSE LAST NAME _____ **FIRST NAME** _____ **MI** _____

DATE OF BIRTH _____ PHONE _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

PRIMARY INSURANCE _____ PHONE _____

INSURED _____ ID# _____ GROUP# _____

SECONDARY INSURANCE _____ PHONE _____

INSURED _____ ID# _____ GROUP# _____

PRIMARY CARE PHYSICIAN _____ **PHONE** _____

REFFERING PHYSICIAN _____ **PHONE** _____

IN CASE OF EMERGENCY

NAME _____ PHONE _____

AUTHORIZATIONS AND RELEASE (PLEASE INITIAL BELOW)

_____ I am aware that I am responsible to pay co-pays and deductibles set forth by Medicare or Commercial Insurance Plans at the time of service.
_____ I hereby authorize by signing below to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under Medicare or Commercial Insurance Plans be made payable directly to Sahai Surgical Specialists, PLC and/or Aalok Sahai, MD, Rohit Sahai, MD, Irina Bernescu, MD. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.
_____ I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I understand that there will be additional costs accessed in addition to my account balance. This additional amount could be as high as 33%.
_____ I am aware that if I request my medical records, I understand to allow 7-10 days for the process of the release of medical records.
_____ I am aware of a $25.00 fee for FMLA or Disability Paperwork. I understand this is to be paid at the time of retrieving my FMLA or Disability Paperwork.

By signing below, I acknowledge that I have read and understand the above statements.

PATIENT SIGNATURE _____ **DATE** _____

PARENT OR GUARDIAN (IF MINOR) _____ **DATE** _____

INDUSTRIAL INFORMATION

INDUSTRIAL INJURY __ YES __ NO TYPE OF INJURY _____ DATE OF INJURY _____
INDUSTRIAL INSURANCE NAME _____ CLAIM# _____ PHONE# _____
NAME OF CASE MANAGER

SAHAI SURGICAL

MEDICAL HISTORY

DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

PCP: _____

REFERRING DR: _____

CHIEF COMPLAINT:

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

	Yes	No
Heart Disease		
Hypertension		
High Cholesterol		
Diabetes		
Stroke/TIA		
COPD		
Bleeding Disorder		

Cancer: _____

OPERATIONS/HOSPITALIZATIONS	Date

CURRENT MEDICATIONS	Dosage

DRUG ALLERGIES

	Reaction

SOCIAL/PERSONAL HISTORY

Occupation			
Marital Status?			
Do you Smoke?	Yes ___ No ___ Date Quit ___	How Long? ___	
Do you drink Alcohol?	Yes ___ No ___ Date Quit ___		
Are you Pregnant?	Yes ___ No ___		
Last Menstrual Period			

FAMILY MEDICAL HX - MAJOR ILLNESSES

	Illness
Father / Living:	
Mother / Living:	
Siblings:	
# of Brothers	
# of Sisters	

SYSTEM REVIEW -

PLEASE CHECK ANY OF THE FOLLOWING YOU MAY HAVE HAD OVER THE PAST YEAR

	Yes	No		Yes	No
Fever			Joint Pain		
Chills			Morning Stiffness		
Night Sweats			Swelling		
Weight Loss			Skin Disorder		
Headaches			Weakness		
Double Vision			Numbness/Tingling		
Blurry Vision			Dizziness		
Hearing Loss			Depression		
Short of Breath			Anxiety		
Cough			Alcoholism		
Coughing Blood			Illegal Drug Use		
Stomach Ulcers			Thyroid Disease		
Blood in Stool			Anemia		
Diarrhea			Abnormal Bleeding		
Constipation			Bladdder/Bowel		
Liver Disease			Incontinence		
Kiddney/Bladder Inf					
Chest Pain					

SAHAI SURGICAL

AALOK K. SAHAI, M.D.
ROHIT K. SAHAI, M.D.

FINANCIAL POLICIES AND ARRANGEMENTS

Sahai Surgical Specialists, PLC recognizes the need for understanding the areas of payment arrangements and insurance filings. Below will explain the protocols of our office.

1. INSURANCE, FILING/BENEFITS/PAYMENTS

There are numerous insurance plans with which Sahai Surgical Specialists have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa and Mastercard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered

If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be files. It is your responsibility as a patient to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment with 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

2. PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, Sahai Surgical Specialists recognize the need to set up payment plans for patients who require extensive treatment. Our Office Manager will be happy to make these arrangements.

3. DELIQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency with additional fees assessed, unless prior arrangements have been made with our Office Manager. If you have questions or feel an error has been made, please request to speak to our Office Manager.

4. RETURNED CHECKS

There is a $40.00 service fee for checks returned for insufficient funds. Sahai Surgical Specialists belong to the Maricopa County Attorney's Check Enforcement Bureau. Sahai Surgical Specialists will request a copy of your Driver's License or State ID card at your initial appointment for identification.

5. CANCELLATION OF APPOINTMENTS/NO SHOW APPOINTMENTS

If you cancel an appointment, Sahai Surgical Specialists request you give a 24 hour notice for consultations and 48 hours for any type of office procedure or surgery. If you fail to cancel your appointment, you may be charged a $25.00 fee as a no-show. If there is a consecutive repeat of 3 no-shows, then this could possibly be grounds for dismissal from Sahai Surgical Specialists.

6. ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they may determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.E. routine exam/lab work, procedures and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

ADDITIONAL HELP

Please feel free to discuss any concerns you may have with our Office Manager or Staff. Sahai Surgical Specialists are dedicated to making your visits with us a pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policy of **Sahai Surgical Specialists.** I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/Guardian Signature: _____ Date: _____

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Irina Bernescu, M.D.

PATIENT'S BILL OF RIGHTS

- You have a right to seek consultation with the physician(s) of your choice
- You have a right to contract with your physician(s) on mutually agreeable terms
- You have a right to talk privately with your physician(s) and to have your health care information protected
- You have a right to use your own resources to choose the care of your choice
- You have a right to refuse medical treatment even if it is recommended by your physician(s)
- You have a right to be informed about your medical condition/treatment and take part in decisions about your care. To be informed about the risks and benefits of treatment and appropriate alternatives
- You have a right to refuse third-party interference in your medical care, and to be confident that your actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians
- You have a right to receive full disclosure of your insurance plan explaining the coverage and benefits

Patient Name: _____ DOB: _____ DATE: _____

SAHAI SURGICAL

PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Sahai Surgical Specialists of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Sahai Surgical Specialists has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this Sahai Surgical Specialists at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand the information will be used/disclosed for the following purposes:

1. To inform me of my medical condition(s) by phone, mail, email or in person
2. To give information/referrals/medical records/samples/prescription/test results to you or the person(s) named on this form by phone, mail, email or in person
3. For treatment, payment and health care operations

I understand that I may request in writing how Sahai Surgical Specialists restricts my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Sahai Surgical Specialists are not required to agree to my requested restrictions, but if Sahai Surgical Specialists does agree, then the practice is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Sahai Surgical Specialists have taken action relying on this consent.

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PERSON(S) BELOW:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Patient Name: _____ Date: _____
Please print

Relationship to Patient: _____

SAHAI SURGICAL SPECIALISTS, PLC
Aalok K. Sahai, M.D.
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Chandler, Arizona 85225

SAHAI SURGICAL

AALOK K. SAHAI, M.D.
ROHIT K. SAHAI, M.D.
IRINA BERNESCU, M.D.
963 N McQueen Road
Chandler, Arizona 85225
Office: 480-646-8440 Fax: 480-646-8441

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that Sahai Surgical Specialists release my medical records to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I hereby authorize and request my medical records to be released to Sahai Surgical Specialists from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I authorize to release the following information:

☐ History & Physical ☐ Lab Reports ☐ XR/MRI/CT Scan/EMG ☐ Discharge Summaries
☐ Consultations ☐ Pharmacy/Medication Profile ☐ All Available Records

Patient Name: _____ DOB: _____
Print Name Please

Patient Signature: _____ Date: _____

When requesting release of records, please allow us 7-10 days for processing – Thank you