

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ DOB: _____ Sex: _____

* Cell/Pager # _____ ***REQUIRED: Please provide for emergency notifications.**

Home Tel # _____ Work Tel # _____

E-Mail: _____

Soc. Sec. # _____

Name of Business: _____ Occupation: _____

Address of Business: _____

***Referred By (please list name):** () Physician _____ () Friend _____

() Insurance _____ () Other _____ ** Please provide a specific source of referral.*

Referring Physician's address: _____ **Tel #** _____

Family Physician/Primary Care Physician: _____

Address: _____ Tel # _____

Emergency Contact Name: _____ Tel # _____

Would you like us to leave information concerning your lab and biopsy results on your phone voice mail? () Yes () No

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Address For Claims: _____

Address For Claims: _____

Insured's Name: _____

Insured's Name: _____

Insured's DOB: _____

Insured's DOB: _____

Soc. Sec. # _____

Soc. Sec. # _____

Policy # _____

Policy # _____

Group # _____

Group # _____

Relationship: _____

Relationship: _____

I hereby consent to the Notice of Privacy Practices currently in force by **KRISHTUL MEDICAL ASSOCIATES, PLLC**. I certify by my signature that I read and understand the information disclosed in the reverenced notices. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of current notice can be obtained at no charge, upon request. I confirm that the information provided above is truthful and accurate, and any discrepancy may result in further clarification.

I authorize **KRISHTUL MEDICAL ASSOCIATES, PLLC** to furnish information concerning my illness and treatment to my insurance carriers.

I authorize payment of medical benefits to **KRISHTUL MEDICAL ASSOCIATES, PLLC**.

I understand that I am responsible for any part of the charges that are not covered by medical coverage.

SIGNATURE: _____

TODAY'S DATE: _____

(Patient or Parent/Guardian if patient is a minor)

FINANCIAL POLICY

- **COPAYMENTS** – We are required to collect your insurance copays at the time of service.
- **REFERRALS** – If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain one prior to your appointment and present it at the time of visit. Without such referral, you will be asked to sign a **FINANCIAL WAIVER** and will be responsible for the fees incurred during the visit. Since referrals have expiration dates, please check before scheduling follow-up appointments.
- **NON-PARTICIPATING INSURANCE PLANS** – Full payment is expected at the time of visit unless special arrangements have been made prior to your visit. You will receive an itemized receipt which should be attached to your insurance claim if you wish to seek reimbursement directly from your carrier.
- **NO-SHOW POLICY** – We ask for 24 HOUR advance notice for all appointment cancellations. We reserve the right to charge \$75 for continued no shows and same day cancellations.
- **RETURNED CHECKS** – We have a service fee of \$50 for returned checks. In the event that outside collection agency or attorney has to be involved debt collection, you will be responsible for all costs incurred during the process.

Thank you for taking the time to review our policies and feel free to ask any questions.

SIGNATURE: _____
(Patient or Parent/Guardian if patient is a minor)

TODAY'S DATE: _____

