PATIENT REGISTRATION FORM

Please complete all sections. The patient, if an adult is regarded as being responsible for all charges generated.

Date: ______________________

Last Name: __________________ First: ______________________ S.S#: ______________________

Address: ________________________________ City:____________ State: _____ Zip: __________

Sex: _____ Age: ___________ Date of Birth: ________________ Marital Status: _______________

Phone Numbers: Home: _________________ Cell: ___________________ Work: _________________

Email: ________________________________ Pharmacy: ________________ Phone: ______________

Emergency contact (not living with you): Last: ________________________ First: ____________________

Relationship to Patient: ___________________ Phone: _________________ Alt: _________________

Address: ____

INSURANCE INFORMATION

Person responsible for account: Last: ___________________________ First: ______________________

Relationship to Patient: _______________ Date of Birth: _______________ S.S #: _________________

Address (if different from above): ____

City: ____________________________ State: ______________________ Zip: ___________________

Insurance Company: ________________________________ Contact #: __________________________

Subscriber #: _______________________________ Group #: __________________________________

Name of Insured on Card: ____

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

SECONDARY INSURANCE

Insurance Company: _________________________________ Contact #: ___________________________

Subscriber #: ________________________________ Group #: ___________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dr. Vani Ramesh, M.D. or Dr Sujatha Subramanian, M.D. all insurance benefits, if any, due to me under by insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Responsible Person/Patient Signature: _______________________________ Date: _________________

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ____ Date of Birth: ______________
Last First

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.

4. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

5. I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

6. I understand that the physician may charge a $35.00 or $55.00 fee if I do not show up for my appointment or cancel without a 24 hour notice.

7. I understand that if I need a copy of my medical records, a printing fee will be charged.

8. I understand that any forms to be filled out by the physicians will have a fee assessed.

9. I understand that I will be required to provide a valid form of payment, either check or credit card which will be run electronically.

10. I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

Signature: ____ **Date**: _________________
(Please sign here – Patient or responsible party)

Responsible
Party Name: ____
(Please print name of Responsible Party if different from Patient)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 31st, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made these changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to another healthcare provider for:

a) The provision, coordination, or management of health care and related service by healthcare providers;
b) Consultation between health care providers relating to a patient;
c) The referral of a patient for health care from one health care provider to another, or
d) Recall information

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include:

a) Billing and collection activities and related data processing;
b) Actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
c) Medical necessity and appropriateness of care reviews, utilization review activities; and
d) Disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our health care operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may gives us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without prior authorization.

To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you an opportunity to object to such uses of professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost based

fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to request a list of instances in which we or our business associates disclosed your information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities for the last 6 years, but not for disclosure made prior to July 31st, 2003. If you request this accounting we may charge you a reasonable fee for responding to these requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternate locations. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You may also submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

SHIVA MEDICAL CARE CENTER
6853 COIT ROAD, STE 300 PLANO, TX 75024
PH: 972-943-0736
FAX: 972-943-7921

Authorization for Disclosure of Health Information

Patient Name: ____

Date of Birth: ________________________________ Phone: ________________________________

Address: ____

City: ______________________________________ State: ______________________ Zip: _________

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

SHIVA MEDICAL CARE CENTER
6853 COIT RD STE. 300
PLANO TEXAS 75024

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records _____ Lab results/X-ray reports

_____ Physical exam _____ Consultation reports

_____ Immunization record

_____ Other (please specify: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to the following individual(s).*

Name: ____

Address: ____

City: ______________________________________ State: ______________________ Zip: _________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________

____

______________________________________ ______________________________________

Signature of patient or legal representative *Signature of witness*

Date: _________________________________ Date: ______________________________________

MEDICAL HISTORY

Date: ___________________

Name: ____

D.O.B: ___________________ Age: ____ Sex: ____ Single / Married / Divorced / Widowed / Separated

Race: __________________________ Ethnicity: ____________________ Language: ______________________

Address: ____

Home Phone: _________________ Occupation: ___________________ Work Phone: __________________

If married, spouse's name: ____

Children's names and ages: ____

____

Allergies to Medications, X-Ray Dyes, or Other Substances? ☐ **No** ☐ **Yes**

If Yes, please list name of medicine and type of reaction

Name	Reaction
____	____
____	____

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Past Medical History and Review of Systems

Please check if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in Bowel Habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Difficulty Urinating
☐ Heart disease	☐ Tuberculosis	☐ Gall bladder disease	☐ Skin diseases
☐ Chest pain/tightness	☐ Hay Fever	☐ Colitis	☐ Blood disorders
☐ Shortness of breath	☐ Headache	☐ Hepatitis or Jaundice	☐ Venereal diseases
☐ Swollen ankles	☐ Thyroid Disease	☐ Anxiety	☐ Depression
☐ Palpitations	☐ Indigestion	☐ Head or neck radiation	☐ Anemia
☐ Lightheadedness	☐ Nausea	☐ Abdominal discomfort	☐ Alcohol abuse
☐ Frequent urination	☐ Vomiting	☐ Kidney disease	☐ Drug abuse
☐ Rheumatic fever	☐ Constipation	☐ Kidney stones	☐ Gout
☐ Asthma	☐ Diarrhea	☐ Impotence or Erectile Dysfunction	☐ Other

____

____

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of periods: __________ Frequency: ____________________ Length of Period: _______________

Pregnancies: ___________________ Births: ______________________ Miscarriages: _________________

Prolonged or abnormal bleeding ☐ No ☐ Yes (If yes, please describe) _________________________

Leakage of Urine ☐ No ☐ Yes (If yes, please describe) _________________________

Pelvic Pain ☐ No ☐ Yes (If yes, please describe) _________________________

Abnormal discharge ☐ No ☐ Yes (If yes, please describe) _________________________

History of abnormal Pap smear ☐ No ☐ Yes (If yes, please describe) _________________________

Please list and supply the dates of:

Operations: _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Hospitalization other than for surgery: _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Immunization history-have you had:

Hepatitis B? ☐ Yes ☐ No Flu ☐ Yes ☐ No Other ☐ Yes ☐ No

Pneumovax? ☐ Yes ☐ No Tetanus ☐ Yes ☐ No

When was your last:

Pap Smear? ______________________ Breast Exam? ___________________ Colon Cancer Test? ___________

Mammogram? ____________________ Cholesterol check? _______________ Prostate Exam? _______________

Family History					Check if your blood relatives had any of the following	
Relation	Age	State of Health	Age at Death	Cause of Death	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Prevention			
Do you wear seat belts?	☐ Yes	☐ No	If no, why not? ____________________
Do you wear a bike helmet?	☐ Yes	☐ No	N/A
Do you exercise regularly?	☐ Yes	☐ No	If yes, duration and number of times per week ________
Do you smoke?	☐ Yes	☐ No	If yes, how many packs per day ____________________
Do you drink alcoholic beverages?	☐ Yes	☐ No	If yes, how much per week ____________________
Do you drink coffee?	☐ Yes	☐ No	If yes, how many cups per day ____________________
Do you drink tea?	☐ Yes	☐ No	If yes, how many cups per day ____________________
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	N/A
Do you use drugs (marijuana, cocaine, etc)?	☐ Yes	☐ No	If yes, explain ____________________
Have you ever engaged in any activity that has put you at risk of getting AIDS?	☐ Yes	☐ No	If yes, explain ____________________
Do you wish to be tested for AIDS?	☐ Yes	☐ No	If yes, explain ____________________
Have you ever worked with chemicals, paints, asbestos or other hazardous material?	☐ Yes	☐ No	If yes, explain ____________________
Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	☐ Yes	☐ No	
Do you ever feel afraid of your partner?	☐ Yes	☐ No	N/A
Do you have a 'living will'?	☐ Yes	☐ No	
Do you have a donor card?	☐ Yes	☐ No	
Are you currently using a method of birth control?	☐ Yes	☐ No	If yes, what method ____________________

E- PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Shiva Medical Care Center (Dr. Vani Ramesh and/or Dr. Sujatha Subramanian) can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ Understanding all of the above, I ________________________________, DOB __________ hereby provide informed consent to Shiva Medical Care Center (Dr. Vani Ramesh and/or Dr. Sujatha Subramanian) to enroll me in the ePrescribe Program.

☐ I ________________________________, DOB ____________ do not give consent to obtain my external prescription history and I hereby state that I will not hold Shiva Medical Care Center (Dr. Vani Ramesh and/or Dr. Sujatha Subramanian) accountable for any untoward consequences arising out of this decision.

______________________________ ______________________

(Signature) *(Date)*

______________________________ ______________________

(Witness Signature) *(Date)*