

Patient Registration Form

Date: _____

Thank you for selecting our facility for your medical care.
We are committed to do the very best we can to provide you with excellent professional care.

PATIENT INFORMATION

Name: (F) _____ (MI) ____ (L) _____ SS or Patient ID: _____
 Address: _____ P.O. Box or Apt #: _____ Home Phone #: (____) _____
 City: _____ State: ____ Zip: _____ Cell Phone #: (____) _____
 Gender: Male Female Trans Married Widowed Single Minor
 DOB (MM/DD/YY): _____ Age: _____ Separated Divorced Partnered for: _____ years
 Name of Employer: _____ Occupation: _____
 Address: _____ P.O. Box or Apt #: _____ Work Phone #: (____) _____
 City: _____ State: ____ Zip: _____ Full-time Part-time Retired

PARENT/GUARDIAN INFORMATION (if patient is under 18 years of age):

Name: (F) _____ (MI) ____ (L) _____ Social Security#: _____
 DOB (MM/DD/YY): _____ Relationship: _____ Cell Phone #: (____) _____
 Name of Employer: _____ Occupation: _____
 Address: _____ P.O. Box or Apt #: _____ Work Phone #: (____) _____
 City: _____ State: ____ Zip: _____ Full-time Part-time Retired

INSURANCE (PRIMARY) INFORMATION

Policy Holder: (F) _____ (MI) ____ (L) _____ Social Security#: _____
 Address: _____ P.O. Box or Apt #: _____ Home Phone #: (____) _____
 City: _____ State: ____ Zip: _____ Work Phone #: (____) _____
 DOB (MM/DD/YY): _____ Relationship: _____ Policy #: _____
 Insurance Company _____ Group #: _____

☞ Please present insurance cards and valid government ID (ex: driver's license) to the receptionist so copies can be made ☜

DO WE HAVE PERMISSION TO:

- Leave a message on your answering machine at home or cell phone? Yes No
 - Leave a message at your place of employment or with a co-worker? Yes No
 - Discuss your medical condition with any member of your household? Yes No With whom: _____
- If applicable, please notify us of any particular restrictions you may want regarding discussing information via phone: _____

PATIENT ACKNOWLEDGEMENT FOR NOTICE OF PRIVACY PRACTICE

- Use and Disclosure of Protected Health Information -

I understand that Dr. Sudhir Gulati may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received (either today or in the past) or been offered a copy of the practice's Notice of Privacy Practices, which provides information about how the practice, and individuals involved in my care at the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment, or health operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at anytime, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

I have been advised of Ladysmith Urgent Care's Privacy Notice with an effective date of February 1, 2005.

Signature of Patient or Parent/Guardian (if patient is minor)

Date

Please Print Name of Patient or Parent/Guardian (if patient is minor)

Relationship to Patient

Thank you for selecting our facility for your medical care.
We are committed to do the very best we can to provide you with excellent professional care.

INSURANCE

I certify that I, and/or my dependent(s), have insurance coverage with the one I listed on the *Patient Registration* page of this packet and assign directly to Dr. Sudhir Gulati, M.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the previously named insurance company and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or three years from the date signed below.

I understand that primary insurance claims will be filed on my behalf for those insurance companies with which Dr. Gulati is a participating provider. We do not file with secondary insurance's nor bill 3rd party insurance's (such as homeowner's, auto or boat insurance). I will furnish complete and accurate insurance information including pre-authorizations and/or referrals, prior to my office visit. I understand it is ultimately my responsibility to be aware of my covered benefits. If Dr. Gulati is an out-of-network provider with my insurance company, I agree to be responsible for amounts not paid by my insurance carrier. If we do not participate with your insurance, we will provide a receipt as proof of payment that you may send to your insurance company for possible reimbursement based on your personal policy/benefits

WORKMAN'S COMPENSATION

As a courtesy to our patients, we will bill your employer for treatment for work-related injuries. Such billing requires you to notify your employer before coming to Ladysmith Urgent Care. Before treatment, we will require employer verification of your work status. We also need your employer's agreement to pay for treatment. You will be responsible for payment if your employer or insurance company does not respond to our billing. Claims not settled within 30 days will be due from you upon demand.

PAST DUE ACCOUNTS

In consideration for the services rendered under this agreement, the undersigned hereby agrees to pay 18% interest per annum on all balances which are overdue and unpaid thirty (30) days after the services are rendered. In the event the undersigned fails to promptly pay for the services rendered under this agreement, the undersigned specifically authorizes the release or personal credit information to any credit reporting agencies. The undersigned further agrees to pay all costs of obtaining such credit information and/or by locating the undersigned, as per necessary. Delinquent account information will be forwarded to the credit bureaus and will appear on your credit report. Any accounts being sent to the credit bureau will be charged a processing fee of \$25.00.

COURT APPEARANCES

For overdue accounts, I also agree to pay an attorney's fee which is hereby stipulated to be 33½% of such outstanding balance, plus court costs, whether suit is filed or not. Should my attorney or I request testimony from Dr. Gulati, I agree to pay \$250.00 per hour, portal to portal, plus mileage based on current IRS guidelines. A retainer may be required. In the event that records or other materials are subpoenaed, a charge will be made for copying and file preparation.

LETTERS/REPORTS/PHONE CALLS

I agree to pay a pro-longed office visit fee depending on preparation time required to prepare letters and reports and/or to make phone calls that I request be sent or made to outside parties, including communications with attorney's and items prepared for court appearances.

DUPLICATION OF RECORDS

Should my attorney request copies of records, I agree to pay charges allowed by VA state law. The charges permitted for copying are \$0.50/page for the first 50 pages and \$0.25 for all remaining pages. Additionally, a search and handling fee of \$15.00 plus all postage and shipping costs are allowed. My records will be faxed at no charge to any physician who submits a release of records form signed by me.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize Ladysmith Urgent Care, its physicians and employees, to release to my insurance companies or other third party agencies, any further information required in connection with payment for services. I understand I am responsible for all charges whether or not covered by an insurance plan. If Ladysmith Urgent Care has filed an insurance claim on my behalf and the claim is not satisfied in 30 days, I will make payment in full, upon demand. I understand that payment is due at the time of service. I have read and fully understand the conditions of this statement.

I have read, fully understand, and accept the above terms and conditions:

Signature of Patient or Parent/Guardian (if patient is minor) _____
Date

Please Print Name of Patient or Parent/Guardian (if patient is minor) _____
Relationship to Patient

Consent and Guidelines

Date: _____

Thank you for selecting our facility for your medical care.
We are committed to do the very best we can to provide you with excellent professional care.

I welcome the opportunity to serve your urgent care needs and will strive to do my utmost to help you by offering you the best medical care I know how. Everything we discuss is protected by rules of confidentiality, and no information about you will be released to anyone at any time without your written consent (except in response to subpoena).

As your physician, I will honor my obligations to:

1. Provide the best quality care I can
2. See you in a timely fashion
3. Refer you accordingly to other medical specialists, if necessary
4. Refer you accordingly for counseling, if necessary
5. Confer with whomever you feel comfortable, with your written consent
6. Fill out forms required by your health plan
7. Fill out whatever additional forms you require when appropriate
8. Help you apply for disability when indicated
9. Write letters required (e.g., concerning leave from school, worker's compensation) when appropriate
10. Write a letter of referral to other doctors when called for
11. Send a copy of your records to the appropriate person when requested to do so by you
12. Call in prescriptions to the pharmacist when indicated
13. Honor patient confidentiality
14. Provide you with samples of medications (if I have them) when required

Summary of Reasons for Discharge

1. Failure to treat the office staff politely, respectfully, and non-abusively. You have the right be treated with kindness and we expect the same consideration.
2. Failures to pay an outstanding balance after numerous notifications.
3. You have an obligation to return for an appointment before your medication runs out provided that you are on a long-term medication.
4. We need up to 48 business hours to respond to requests for prescription renewals. If these requests occur on a regular basis because of non-scheduled appointments, it could result in discharge.
5. Returns of phone calls for non-urgent and non-emergency matters might have to wait until the following business day.
6. Misuse of any controlled drug, including stimulants, tranquilizers, pain relievers, or frequent "loss" of prescriptions will result in discharge.
7. *Persistent* noncompliance with treatment.
8. Alteration of any prescription.
9. A decision to re-admit you as an active patient will be made on an individual basis.

If you cannot accept and live with any of these guidelines, please seek treatment elsewhere.

I have read these guidelines, agree to abide by them, and understand that continued treatment cannot be provided unless I do so.

Signature of Patient or Parent/Guardian (if patient is minor)

Date

Please **Print Name** of Patient or Parent/Guardian (if patient is minor)

Relationship to Patient