SRILATHA REDDY, M.D. P.A.
FAMILY HEALTH & WELLNESS CENTER

3600 Conflans Rd.Suite 100
Irving, TX 75061
972-870-0788 ph
972-262-2263 fax

In general, the HIPPA privacy rule gives the individual the right to request restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

PATIENT INORMATION

PLEASE PRINT

DATE_____

LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS CITY STATE ZIP

_____
BIRTHDATE

SEX:___M ___F MARITIAL STATUS: ___S ___M ___D ___W ___SEPR

( ) _____ - _____ HOME PHONE ____ OK TO LEAVE MESSAGE WITH DETAILED INFROMATION

____ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

( ) _____ - _____ CELL PHONE ____ OK TO LEAVE MESSAGE WITH DETAILED INFROMATION

____ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

( ) _____ - _____ WORK PHONE ____ OK TO LEAVE MESSAGE WITH DETAILED INFROMATION

____ LEAVE MESSAGE WITH CALL BACK # ONLY

_____
SOCIAL SECURITY# DRIVERS LICENSE #

_____
OCCUPATION

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EMPLOYER (GUEARDIAN'S EMPLOYER) EMPLOYER PHONE NUMBER / EXT.

EMPLOYER ADDRESS

SPOUSE / PARENT NAME	EMPLOYER	EMPLOYER PHONE # / EXT.
SPOUSE / PARENT SOC. SEC. #	DATE OF BIRTH	
PRIMARY INSURANCE	POLICY #	GROUP #
SECONDARY INSURANCE	POLICY #	GROUP #
EMERGENCY CONTACT	ADDRESS	PHONE #

ALL COPAYS AND/OR BALANCES MUST BE COLLECTED IN FULL AT THE BEGINNING OF EACH VISIT. PLEASE REMEMBER THAT THE INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT AND ALL DEDUCTIBLES AND PERCENTAGES DUE BY THE PATIENT ARE TO BE PAID BEFORE EACH VISIT. I UNDERSTAND THAT IF I DO NOT PAY SERVICES AS RENDERED THE ACCOUNT WILL BE FORWARDED TO A COLLECTION AGENCY AND I WILL BE RESPONSIBLE FOR ANY FEES AS A RESULT OF COLLECTION ACTIVITY.

SIGNATURE OF RESPONSIBLE PARTY AGREED DATE

HOW DID YOU HEAR ABOUT US?

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ADVANCED CARE DIRECTIVE

DO YOU HAVE AN ADVANCED CARE DIRECTIVE? YES NO

An advanced care directive are specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future. This is also known as power of attorney, do not resuscitate (DNR), or living will.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practice's, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____

Date

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Release of Information

This serves as authorization for the following person or persons to sit in for the consult, provide information about my illness, and request information at anytime in person or by phone.

Name: _____Relationship:_____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name:_____Relationship:_____

_____

Patient's Signature Date

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FINANCIAL POLICY

The type of relationship we maintain with our patients is important to us in an effort to prevent misunderstanding; it has become necessary to implement the following guidelines;

Effective January 01, 2007, payment for Family Medicine Services will be due at the time the services are rendered. All charges are patient's responsibility regardless of insurance benefits. We file insurance as a way to assist you in reducing your out of pocket expenses. Therefore, if we are able to verify benefits in advance and get information relating to coverage and limitations, we require that you pay the deductibles and percentages not covered by insurance on the date of service. We are happy to file your insurance for the remaining portion they claim to cover. Please understand our difficulties in collecting the money from insurance companies. We are simply the providers of medical services to you. Therefore, the more you know about your coverage, the better it is. Whenever there are claim disputes, we will request that you contact your insurance company for clarification.

If an insurance payment is not received within 45 days of the date of service, you will be required to pay the insurance portion regardless of the status of the claim. This balance will be due in our office 15 days from the date of the statement. If any insurance benefits are received after you have cleared your account, we will forward the insurance check to you. If a balance remains after insurance pays, you will receive an explanation of benefits from your carrier that you can refer to for coverage information. If you need more detailed information regarding what was or was not paid, please call your insurance company.

METHODS OF PAYMENT & INTEREST RATE ON UNPAID BALANCES:

We accept cash, Visa and Master card. We do charge an interest rate of 18% annually that begins on the date services are rendered. However, if you and/or your insurance company pay the entire balance in full within 45 days of treatment, we will waive the interest. If the balance is not paid within 45 days, the interest will be added to the balance.

COLLECTION:

All accounts over 60 days old will be considered delinquent and payable immediately. If payment is not received by 90 days, the account will be referred to an outside collection agency or attorney's office and will be reported to the credit bureau. The patient or responsible party will be responsible for all attorney's and/or collection agency fees and court costs. As always, our primary goal is to provide the finest Family Medicine Care to all our patients. Thank you for your cooperation in assisting us in this process.

_____

Patient' s Signature Date