Dr. Rajesh Madan M.D

New Patient Registration Form ***PLEASE PRINT CLEARLY***

Date: _____
Last Name: _____ First Name: _____
Date of Birth: _____ Social Security #: _____
Maiden Name: _____ Age: _____ Gender: _____
Street Address: _____
City: _____ State: _____ Zip:_____ Marital Status: S M D W
Home (_____)_____-_____ Cell (_____)_____-_____
Work (_____)_____-_____ ex: _____ Employer Name: _____
Email: _____
Race: _____ Hispanic: _____ Yes _____ No
Language Preferred: _____
Pharmacy Preferred Name: _____ Location: _____

Emergency Contact Information

Emergency Contact Last Name: _____ First Name: _____
Relationship:_____ Phone Number: (_____)_____-_____

Primary Insurance Information

Insurance Company Name: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship to Patient: ____ Self ____ Spouse ____ Parent ____ Legal Guardian

Secondary Insurance Info

Insurance Company: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship to Patient ____ Self ____ Spouse ____ Parent ____ Legal Guardian

INSURANCE CARD AND COPAY, IF YOU HAVE ONE, MUST BE PRESENTED AT EVERY VISIT

In order to submit a claim for payment to us for service covered under your policy we must have your authorization to release medical information to your carrier; I hereby authorize release of information to file a claim with my insurance company. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. I also hereby consent to the treatment provided by Dr. Rajesh Madan and authorize my insurance benefits to be paid directly to Rajesh Madan M.D.

_____ _____
Patient Signature or Parent/Guardian Signature Date

Dr. Rajesh Madan M.D

Our office is committed to protecting your right to privacy. Due to HIPPA Act, which went into effect April 14, 2003, we are legally not allowed to release information about your health care to anyone without your written permission.

On the lines below please list the names of anyone, friend or family, whom we are allowed to release information, such as lab and x-ray results, appointments, prescription information, and other things that may be related to your care:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Personal Contact Information

Cell Phone Number _____

What is the best time of the day to reach you? _____

May we leave messages? Yes _____ No _____

May we contact you at work? Yes _____ No _____

_____ _____

Patient Signature or Parent/Guardian Signature Date

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, RAJESH MADAN, MD, PC Originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent
- The right to object to the use of my health information for directory purposed, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that RAJESH MADAN, MD, PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that RAJESH MADAN MD, PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should RAJESH MADAN MD, PC change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

_____

Patient Signature or Parent/Guardian Signature

_____

Date

Dr. Rajesh Madan, M.D.

Financial Policies

It is the policy of our office to collect any payment due at the time services are rendered. For patients who have health insurance, we will bill your insurance company for services provided. However, any co-payments or coinsurance will be expected at the time of the visit. We reserve the right to deny any services if payment is not provided. It is the patient's responsibility to ensure that we are provided accurate insurance information. Any services not covered by your insurance company will be billed to you. If those payments are not received in a timely manner, the account may be given to account collection agency for further collection attempts.

For patients that do not have insurance, we do offer flat rate fees for office visits and services. Upon your request we will provide you with a list of those charges. Payment is expected at the time the services are rendered.

If you neglect to pay your balance with our office in a timely manner, your account will be sent to collections. There will be an additional charge placed on your account of 20% of your balance due. This will be due to the fees to transfer your account to the collections agency.

We understand that financial hardships may occur and may be willing to work with you in the event you are unable to pay your bill. Please contact our office immediately if such circumstances arise to avoid your accounts being placed with an outside collection agency.

By signing below you affirm that you have read and understand the above policies.

_____

Patient Signature or Parent/Guardian Signature

_____

Date

OFFICE POLICIES AND PROCEDURES
EFFECTIVE 1/1/13

These policies are also subject to change at any time. If you have any questions, please do not hesitate to ask one of our staff members.

- **Prescription Refill Request Policy:** There is a 24 hour notice required for all refills. Please call ahead of time for refills.
- **Update Policy:** It is the patient's own responsibility to keep us updated on change in address, phone number and insurance information if we do not have updated information. Some insurances allow only 90 days to file a medical claim. Failure to provide updated insurance information, resulting in a claim being denied by your insurance, may become the patient's financial responsibility.
- **Co-Pay Policy:** You must pay your co-pay at every visit if your insurance requires one. You will be responsible to pay your co-pay for annual exams as well, unless listed on your card that your preventative co-pay is $0. This is your responsibility per your insurance. Your insurance may also have a deductible, and this is an amount due other than your co-pay amount.
- **No Show Policy:** We charge a $25.00 no show fee for Saturday appointments only. It is the patients responsibility. This can not be billed to your insurance. Please give us at least 24 hour notice to cancel or reschedule appointments so other patients can be accommodated in the cancelled time slot.
- **Form Fee Policy:** If you need forms filled out by Dr. Madan, there is a fee for this. If it is a one page form, there is no fee!! Anything 2 pages or more, there is a $20.00 fee. This can not be billed to your insurance, and fees are due in order to receive the paper work completed.
- **Procedure/Testing Policy:** We have specialists that come into our office to perform certain tests. I.E.: Nerve Conduction Study, Echo, Etc. Since these specialists only come in once a month we have a cancellation policy for these appointments. You must call 48 hours in advance to cancel these appointments so that we can try to fill your time slot. Failure to do so will result in a $25.00 fee. This can not be billed to your insurance. This is patient responsibility.

Patient Signature:_____ DOB:_____

Printed Name:_____ Date:_____

Rajesh Madan, M.D.
4531 Cemetery Road
Hilliard, OH 43026

P: (614) 527-8787
F: (614) 527-7287

PRIVACY POLICY

IMPORTANT:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, initial evaluations and daily treatment received will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from all sources of coverage such as private insurance carriers. For example, your insurance carrier may request and receive information on dates of service, services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Rajesh Madan, MD. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Disclosures Requiring Your Authorization: Disclosure of your health information (medical records, insurance information, individual picture, etc.) or its use for any purpose other than those listed above require your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your information that occurred before you notified us of your decision.

Appointment Reminders: Your health information may be used by our staff to call for appointment reminders.

Information About Treatment: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Marketing: Your name will not be used for marketing efforts without your written permission.

YOUR PATIENT RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected helath information.
- The right to receive an accounting of how and to whom your protected helath information has been disclosed.
- The right to receive a printed copy of this notice. (This is our printed notice)

RAJESH MADAN, M.D. DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

_____

Patient Signature

_____

Printed Name

_____

Date/Effective