Rajesh Madan, M.D.

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

Last Name: ________________________________ First Name: ___________________________
Date of Birth: _______________________ Social Security #: _________-_________-__________
Maiden Name: _______________________ Gender (circle one): Male Female
Street Address: ____ Apt #: __________
City: ___________________________________ State: _____________ Zip:________________
Marital Status (circle one): Single Married Divorced Widowed
Home (_______)______-_________ Cell (______)______-__________
Work (_______)______-_________ ex: _______ Employer Name: ________________________
Email: ____
Race: ________________________________ Hispanic (circle one): Yes No
Language Preferred: ________________________________
Pharmacy Preferred Name: ________________ Location: ______________________________

Emergency Contact Information

Emergency Contact Last Name: ________________________ First Name: _________________________
Relationship to you:________________________ 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

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, appoinments, 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

Your Cell Phone Number: (_________) ______________________________

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

May we leave you a detailed message? 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:

____

____

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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

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.

You agree, in order for us to provide services for you and your account and/or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read this disclosure and agree that the Practice or an authorized agency representing the Practice may contact me as described above.

____________________________________ ____________________

Patient Signature or Parent/Guardian Signature Date

OFFICE POLICIES AND PROCEDURES
UPDATED 1/1/15

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. Please keep in mind of holidays and office closures, any requests made during office closures will be completely upon reopening.
- **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. 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 $50.00 no show fee for appointments. 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.
- **Statement/Collections Policy:** There will be a 2% charge added to your account if you fail to pay your bill after receiving a statement. Starting from the second statement on, there will be a charge for each one mailed. After 3 statements, accounts are subject to being sent to collections with our collections agency, Meade & Associates. At that time a 25% charge will be added to your account.

OUR OFFICE HOURS ARE AS FOLLOWS FOR SCHEDULING APPOINTMENTS
MONDAY-FRIDAY: 8:30AM-4:30PM
2ND AND 4TH SATURDAY OF THE MONTH: 8AM-11:30AM
***Office hours may change day to day depending on the schedule and the Doctor's availability. Office hours for Holidays will be posted in the office and on our voicemail. The Saturday hours may change as well depending on holidays.

Patient Signature:____________________________________ DOB:_____________

Printed Name:_______________________________________ Date:_____________

NOTE TO PATIENTS REGARDING LAB TESTING

LABCORP NOTICE

PLEASE NOTE THAT WE ORDER THE LAB TESTS ON OUR PATIENTS AS MEDICALLY NECESSARY TO DIAGNOSE AND TREAT YOUR MEDICAL CONDITIONS. BECAUSE COVERAGE FOR BLOOD TESTS CAN VARY FROM INSURANCE TO INSURANCE, IT IS THE PATIENT'S RESPONSIBILITY TO FIND OUT WHAT IS COVERED BY THEIR INSURANCE POLICY. IF YOU DO NOT WANT ANY PARTICULAR BLOOD TESTS DONE FOR ANY REASON, PLEASE NOTIFY US PRIOR TO THESE LABS BEING DRAWN. BLOOD SAMPLES ARE DRAWN BY AND TESTED BY **LABCORP CORPORATION**. LABCORP MAY BILL YOU SEPERATELY FOR ANY AMOUNT DUE AS DETERMINED BY YOUR HEALTH INSURANCE. WE ARE UNABLE TO TAKE ANY REQUESTS FOR CHANGING THE CPT CODES AFTER THE LABS ARE DONE AND REPORTED.

CODES USED FOR ANNUAL EXAMS

AS THE PHYSICIAN'S OFFICE, WE DO NOT KNOW WHAT YOUR INSURANCE COVERS FOR AN ANNUAL PHYSICAL EXAM. BELOW IS A LIST OF TESTS THAT WE NORMALLY DO FOR THIS EXAM. IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THE INSURANCE COMPANY TO SEE WHAT THEY WILL COVER FOR THIS. PLEASE LET US KNOW BY THE END OF THE BUSINESS DAY OF YOUR ANNUAL PHYSICAL IF ANY OF THESE TESTS ARE NOT COVERED AND WE CAN REMOVE THEM FROM THE ORDERED LABS. IF YOU DO NOT CALL US TO CHANGE ANYTHING BY THE END OF THE BUSINESS DAY, WE WILL PRESUME THAT THESE TESTS ARE ABLE TO BE SUBMITTED TO INSURANCE.
THE DIAGNOSIS CODE USED TO SUBMIT TO INSURANCE IS: **Z00.00** (UNLESS OTHERWISE STATED BY THE DOCTOR)

- **CPT CODE: 93000**, EKG (OVER AGE 40)
- **CPT CODE: 85025**, CBC (COMPLETE BLOOD COUNT)
- **CPT CODE: 80053**, CMP (COMPREHENSIVE METABOLIC PANEL-INCLUDES GLUCOSE, ELECTROLYTES, KIDNEY AND LIVER FUNCTION)
- **CPT CODE: 83036**, HBA1C (DIABETES TEST)
- **CPT CODE: 80061**, LIPID PANEL (TOTAL CHOLESTEROL, HDL, LDL AND TRIGLYCERIDES)
- **CPT CODE: 81003**, URINALYSIS (EXCEPT FOR ANTHEM BCBS PATIENTS)

***IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT ANYTHING LISTED IN THIS NOTICE PLEASE ASK A STAFF MEMBER FOR ASSISTANCE. THIS NOTICE IS TO BETTER HELP OUR PATIENTS WITH BILLING ISSUES AND CONCERNS. WE ARE MORE THAN WILLING TO ASSIST YOU WITH ANY ISSUES THAT YOU MAY HAVE.

PATIENT NAME (PRINTED):______________________________________

PATIENT SIGNATURE:____

DATE:__________________

EFFECTIVE 1/1/19
No Show Appointment Policy

A **$50.00 NO SHOW FEE** WILL BE CHARGED FOR All NO SHOW APPOINTMENTS

If you are unable to keep your appointment you must give 24 hour notice in order to avoid the fee.

THIS CAN NOT BE BILLED TO YOUR INSURANCE!
IT IS PATIENT RESPONSIBILITY!!

Patient signature :______________________________**Date:**__________

Print Name: ____________________________________**DOB:**__________