

PATIENT DEMOGRAPHIC FORM

PATIENT LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ GENDER ASSIGNED AT BIRTH: M _____ F _____

MAILING ADDRESS/P.O. BOX: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

PARENT INFORMATION

PARENT #1 LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ OCCUPATION: _____

MAILING ADDRESS/PO BOX: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL# _____

EMAIL ADDRESS: _____

(NEEDED FOR PATIENT PORTAL)

PARENT #2 LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ OCCUPATION: _____

MAILING ADDRESS/PO BOX: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

HOME # _____ CELL# _____

EMAIL ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

MEMBER ID: _____ GROUP #: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

SECONDARY INSURANCE : _____

MEMBER ID : _____ GROUP #: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

EMERGENCY CONTACT NAME: _____ NUMBER: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE: _____

I hereby authorize Bhargesh P. Mehta, M.D., P.A. to apply for benefits for services rendered to (child's Name) _____. I request that payments be made directly to the above named physician, I hereby certify that all of the information I have given with regards to my insurance is correct. Further, I authorize the release of any necessary information I have given with regards to my insurance carrier or the named billing agent. I will be billed (3) times in which I will have ample time to arrange payment plans. I understand that I will be responsible for all charges including collections, court costs, and interest in the event that this account is overdue and referred to collection.

Signature: _____

Date: _____

Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____																																																																																																					
Form Completed By: _____		Today's Date: _____																																																																																																					
Relationship: _____																																																																																																							
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY																																																																																																					
Name of Hospital: _____ Illnesses during pregnancy? No ☐ Yes ☐ Medications during pregnancy? No ☐ Yes ☐ Alcohol/ Drug Abuse? No ☐ Yes ☐ Problems at birth? No ☐ Yes ☐ Describe: _____ Type of delivery ☐ Vaginal ☐ C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No ☐ Yes ☐ Date of Hepatitis B immunization: _____		Who lives in household? _____ _____ How Many? _____ ☐ Rent ☐ Own ☐ Shelter Who cares for your child? _____ Does anyone in the family smoke? No ☐ Yes ☐ If yes, who? _____ Are parents working? Mother No ☐ Yes ☐ Father No ☐ Yes ☐ Foster Care? _____ Dates: _____																																																																																																					
FAMILY HISTORY		PAST HEALTH HISTORY																																																																																																					
How many siblings? _____ ☐ Brother ☐ Sister Age: _____ ☐ Brother ☐ Sister Age: _____ ☐ Brother ☐ Sister Age: _____ ☐ Brother ☐ Sister Age: _____ ☐ Brother ☐ Sister Age: _____ ☐ Brother ☐ Sister Age: _____ Has anyone in the family (parents, grandparents, aunts/ uncles, sisters/ brothers) had: _____ <table border="0"> <tr> <td></td> <td></td> <td>Who?</td> </tr> <tr> <td>TB/ Lung Disease</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>HIV/ AIDS</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Suicide Attempts</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Heart Disease</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>High Blood Pressure/ Stroke</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>High Cholesterol</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Blood Disorders/ Sickel Cell</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Diabetes</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Seizures</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Allergies/ Asthma</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Mental Illness</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Cancer</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Birth Defects</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Hearing/ Speech Problems</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Kidney Disease</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Alcohol/ Drug Abuse</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Hepatitis/ Liver Disease</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Thyroid Disease</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Learning Problems/ ADD</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Family Violence</td> <td>No ☐ Yes ☐</td> <td>_____</td> </tr> <tr> <td>Other:</td> <td></td> <td>_____</td> </tr> </table>				Who?	TB/ Lung Disease	No ☐ Yes ☐	_____	HIV/ AIDS	No ☐ Yes ☐	_____	Suicide Attempts	No ☐ Yes ☐	_____	Heart Disease	No ☐ Yes ☐	_____	High Blood Pressure/ Stroke	No ☐ Yes ☐	_____	High Cholesterol	No ☐ Yes ☐	_____	Blood Disorders/ Sickel Cell	No ☐ Yes ☐	_____	Diabetes	No ☐ Yes ☐	_____	Seizures	No ☐ Yes ☐	_____	Allergies/ Asthma	No ☐ Yes ☐	_____	Mental Illness	No ☐ Yes ☐	_____	Cancer	No ☐ Yes ☐	_____	Birth Defects	No ☐ Yes ☐	_____	Hearing/ Speech Problems	No ☐ Yes ☐	_____	Kidney Disease	No ☐ Yes ☐	_____	Alcohol/ Drug Abuse	No ☐ Yes ☐	_____	Hepatitis/ Liver Disease	No ☐ Yes ☐	_____	Thyroid Disease	No ☐ Yes ☐	_____	Learning Problems/ ADD	No ☐ Yes ☐	_____	Family Violence	No ☐ Yes ☐	_____	Other:		_____	Has your child ever had: Chicken Pox (year) _____ No ☐ Yes ☐ Frequent Ear Infections No ☐ Yes ☐ Vision/ Hearing Problems No ☐ Yes ☐ Skin Problems/ Eczema No ☐ Yes ☐ Asthma/ Allergies No ☐ Yes ☐ Any allergic reaction (s) No ☐ Yes ☐ If yes, describe in detail _____ <table border="0"> <tr> <td>TB/Lung Disease</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Seizures/ Epilepsy</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>High Blood Pressure</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Heart Defects/ Disease</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Liver Disease/ Hepatitis</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Diabetes</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Kidney Disease/ Bladder Infections</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Physical or Learning Disabilities</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Bleeding Disorders/ Hemophilia</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Sexually Transmitted Diseases</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Emotional or Behavioral Problems</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Depression/ Suicidal Thoughts</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Hospitalizations/ Surgeries</td> <td>No ☐ Yes ☐</td> </tr> </table> If yes, when and why? _____ _____ <table border="0"> <tr> <td>Physical/ Emotional / Sexual Abuse</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Bone or Joint Injuries</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Obesity/ Eating Disorders</td> <td>No ☐ Yes ☐</td> </tr> <tr> <td>Any serious injuries</td> <td>No ☐ Yes ☐</td> </tr> </table> If yes, when and how? _____ _____ Current Medication (s): _____ _____		TB/Lung Disease	No ☐ Yes ☐	Seizures/ Epilepsy	No ☐ Yes ☐	High Blood Pressure	No ☐ Yes ☐	Heart Defects/ Disease	No ☐ Yes ☐	Liver Disease/ Hepatitis	No ☐ Yes ☐	Diabetes	No ☐ Yes ☐	Kidney Disease/ Bladder Infections	No ☐ Yes ☐	Physical or Learning Disabilities	No ☐ Yes ☐	Bleeding Disorders/ Hemophilia	No ☐ Yes ☐	Sexually Transmitted Diseases	No ☐ Yes ☐	Emotional or Behavioral Problems	No ☐ Yes ☐	Depression/ Suicidal Thoughts	No ☐ Yes ☐	Hospitalizations/ Surgeries	No ☐ Yes ☐	Physical/ Emotional / Sexual Abuse	No ☐ Yes ☐	Bone or Joint Injuries	No ☐ Yes ☐	Obesity/ Eating Disorders	No ☐ Yes ☐	Any serious injuries	No ☐ Yes ☐
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Bhargesh P. Mehta, M.D., PA

1005 Prince Frederick Blvd
Suite 101
Prince Frederick, MD 20678
Phone: 410-535-5555

3140 West Ward Rd
Suite 207
Dunkirk, MD 20754
Phone: 410-257-1744

Permission to Treat

I, _____ am the parent or legal guardian of:
(Print Name)

Patient(s) Name:

DOB:

I give the following person(s) permission to bring the patients (minors) listed above, to the physician's office and sign for outpatient medical treatment

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

The above mentioned person(s) has my permission to sign for vaccines/injections

(Parent or guardian Initials)

This authorization is effective until date: _____

(Signature of Parent/Legal Guardian)

(Date)

Mehta Pediatrics - Bhargesh P Mehta MD PA
Billing Information for Your Well Check Visit

What is included in a well-check visit?

Think of a well-check as a preventative visit. It's meant to check on how your child is growing and progressing in terms of development and growth. It usually includes:

Physical exam	Growth charts review
Developmental surveillance	Nutrition assessment
Vision/hearing (certain ages)	School performance review
Mental health screen (certain ages)	Vaccinations
Lead/Anemia screen (ages 1&2)	

What is not included in a well-check visit?

As weird as it seems, specific medical complaints or management of chronic conditions are not included in a "well" visit. These include, but are not limited to:

Ear infection	Depression/Anxiety management
Rashes / Eczema / Diaper rash	Developmental delays
Asthma	Tick bite/Lyme disease
Contraception	Labs/imaging tests
ADHD/med management	Colds/illnesses
Allergies/congestion	Behavior problems
Menstrual concerns	Weight checks

And much more....

What does this mean for my visit?

We are happy to address any and all concerns that you may have at your child's well visit (including any "sick" concerns). However, your insurance company requires that we perform appropriate billing and coding for each visit. This means that a **separate medical issue** will be billed **separately** as a "sick" encounter, even if it is discussed during a "well" visit. You may encounter a balance from your insurance (often called a member responsibility) for this additional condition.

If you are unsure of what is covered by your insurance plan, please **contact your insurance company directly**. Please also note that insurance companies change what they will and will not cover each year, so costs related to your visit can change from year to year.

I have read and acknowledged the above information:

Parent/Guardian Signature

Parent/Guardian Printed name

Patient (child) name

Date

HIPAA and Information Notices

I have received a copy of our **Privacy Notice for Bhargesh P. Mehta, M.D., PA.**

Bhargesh P. Mehta, M.D., PA reserves the right to modify the privacy practices outlined in the notice

I have received a written copy of our **Office Policies and Procedures** and agree to abide by the policies within it.

I have received a written copy of our **Patient Financial Responsibility Disclosure** and understand my financial obligation.

I have received a written copy of our **Lab Work Agreement** and understand my financial obligation if my insurance declines payment.

have received a written copy of our **Controlled Substance Policy** and agree to abide by the policies within it.

I hereby give my consent for Bhargesh P. Mehta, M.D., PA, to access all electronic Medical Records on CRISP (Chesapeake Regional Information System for our patients) and any other health institutions.

Patient Name (please print)

Date

Patient or Guarantor Signature

Date

BHARGESH P. MEHTA, M.D., P.A
PRIVACY NOTICE
EFFECTIVE DATE JANUARY 1, 2019

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

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures 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 your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example your health plan may request and receive information on dates of service, the 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 *Bhargesh P. Mehta, M.D., P.A.* 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 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.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information.

Appointment reminders. Your health information will be used by our staff to send your appointment reminders.

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

Fund Raising. *Bhargesh P. Mehta, M.D., P.A. does not do any fund raising*

Individual 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 communication 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 health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Bhargesh P. Mehta, M.D., P.A. 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 and practices 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 regulations. Upon request, we will provide you with the most recently revised notices on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy notice, you can do so by sending a letter outlining your concerns to:

Bhargesh P. Mehta, M.D., P.A.
1005 Prince Frederick Blvd. Suite, 101
Prince Frederick, MD 20678

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concerns to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact further information concerning our privacy notice is:

Bhargesh P. Mehta, M.D., P.A.
1005 Prince Frederick Blvd. Suite 101
Prince Frederick, MD 20678
410-535-5555 or 301-855-1114

**MEHTA PEDIATRICS
JANI INTERNAL MEDICINE**

Office Policy & Procedures

Check in - When arriving at our office, please sign in at the front desk and then have a seat. The receptionist will call you back up to give you any paperwork needed. ***We request updates from all patients every six (6) months. There are no exceptions**

Check-out - Follow-up and routine appointments may be made while checking out. Please give the staff ANY paperwork the physician may have given you, so that they can scan it into your chart.

Health Maintenance - Patients are expected to stay up-to-date on well-child appointments. Sick visits may be declined to patients who are overdue for well-child appointments.

Insurance Cards - Please bring your insurance card(s) to every appointment. If you do not have it, you may be asked to reschedule.

Cancellations/Rescheduled/Missed Appointments - Each time a patient cancels at the last minute or misses an appointment, another patient is prevented from receiving care. We ask that you call within 24 hours of your appointment time to cancel or reschedule your appointment. If you call the same day, it will be documented as a canceled or rescheduled appointment.

Three cancellations/rescheduled or missed appointments within any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

Medical Records - Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written consent. ***Please Note There Is A Fee For Medical Records:**
\$0.57 per page not to exceed \$80 for electronic copies provided in PDF format
\$0.76 per page for photocopies

MVA and Workman's Comp – Our office collects \$150.00 from patients for these visits before services are rendered. These types of visits are considered as a Liability and do not get billed to your Health Insurance unless instructed by a lawyer for denial purposes only. As a courtesy to you, we will bill whatever insurance company you are working with, along with the progress note for that visit. What we need from you is:

- Name of insurance company processing claim
- Address where claim is to be sent
- Name of their adjuster working the claim (if applicable)
- Phone number of the insurance company

Once the claim is processed and our office receives payment, we will reimburse you the \$150.00

Prescription Refills - All prescriptions are done electronically. Please call your pharmacy to send over any requests for refills. * Do not wait till you are out of your medications to do this.

Referrals – Referrals must be requested at least 5 days prior to your appointment unless the visit is an emergency visit. Referrals can be faxed directly to the doctor or picked up at our office. *** If you do not request a referral prior to seeing a specialist, we will not backdate the referral. This violates our contract with the insurance companies. Without a valid referral, you could become responsible for payment of any charges incurred at the specialists office.**

Divorce, Separation, and Custody Agreements (for Pediatric patients) - We believe that such matters should not enter into a patient's medical treatment. We are not a party to your divorce/custody agreement.

The person bringing the child for their appointment is responsible for payment of copays and any outstanding balance. Parents need to make arrangements with whomever is bringing in their child so that payments are made at time of visit.

"Joint custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results. We will not call the other parent for consent prior to treatment. Unless stated in the court order, both parents have equal rights. We will discuss with the accompanying adult information pertinent to the child's history and exam.

If issues regarding these matters become disruptive to our practice or prevent us from providing medical care to a child, the patient will be discharged from our practice.

(Patient Copy)

**MEHTA PEDIATRICS
JANI INTERNAL MEDICINE**

Patient Financial Responsibility Disclosure

Thank you for choosing our practice for your healthcare needs. We are committed to building a successful provider-patient relationship with you and your family. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Medical Insurance - We participate with most insurance plans including state insurances and Medicare, and we bill them as a service to our patients. Please confirm your provider is enrolled with your insurance carrier prior to scheduling your appointment.

If we do participate in your plan, but you do not have a current insurance card or the designated primary care provider is not a provider with our office, payment is required in full for each visit until we verify coverage and you have contacted your insurance carrier to add the correct provider.

Proof of Insurance – If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card at each visit. This information must be provided prior to seeing a provider.

Claim Submission – Your insurance benefit is a contract between you and your insurance company, and charges for any services provided are your responsibility. We will submit claims to your insurance (primary, secondary or supplemental) company on your behalf. In order to submit claims, we require the patients name, address, date of birth as well as the policy holders name, address and date of birth. This information must match exactly how your insurance company has it on file for you. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you will become responsible for the whole amount of the services provided.

Coverage Changes – Please notify our office before your scheduled appointment if any of your insurance information has changed. This includes change of insurance carrier, policy number, group number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement, in which case you will become responsible for the whole amount of the services provided.

Self-Pay Patients – If you are not insured or our office does not participate with your insurance plan, you are expected to pay in full before services rendered, and any additional payments for any in-house services, if done, will be collected after the patient is seen. If subsequent reimbursement by an insurance company is received for those services, the patient will be refunded by our office.

Co-Payments – Copays are to be collected in full before services rendered. As part of our contract with the insurance companies, we are legally required by the terms of the contract to collect any copays from you at the time of service.

Deductibles and Out-of-Pocket Expenses – We will bill you for any outstanding balances once your insurance carrier has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date. Patients with an outstanding balance more than 60 days overdue must make arrangements for payment in prior to scheduling their next visit.

Non-Payment - If a balance remains unpaid past 90 days, your account will be transferred to a collection agency/attorney. Noncompliance with our financial responsibility policy may result in discharge from our practice.

Minors – Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of service.

No shows - Each time a patient misses an appointment another patient is prevented from receiving care. To help minimize the frequency of missed appointments, Bhargesh P. Mehta, M.D., PA reserves the right to charge a fee of \$30 for all missed appointments (No Shows) "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

Returned Check Policy - If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), the patient or patients Responsible Party will be responsible for the original amount in addition to a \$35.00 Service Charge. Once notice is received of the returned check, our office will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the date of letter by the Patient or Responsible Party, the account will be turned over to our collection department.

Account Consultation – Providers and front staff are not trained to discuss financial issues with patients. Only billing staff is trained to discuss your account, including charges, fees, payments and payment arrangements. If you have any questions about any of the financial issues related to your account, please contact our billing office at 410-535-555 option 4

**MEHTA PEDIATRICS
JANI INTERNAL MEDICINE**

LAB WORK AGREEMENT

Your insurance company will be billed for applicable charges for any lab work your physician is ordering for you, by Quest Diagnostics or LabCorp.

As the responsible party, you are responsible for any balance owed, if your insurance company declines to pay for any reason.

If there are any discrepancies with your bill, please call the facility where you had your blood drawn, before calling our office. They have their own billing department and will contact us for coding purposes if needed.

(Patient Copy)

**MEHTA PEDIATRICS
JANI INTERNAL MEDICINE**

CONTROLLED SUBSTANCE POLICY

There are certain medications that are considered controlled substances and must be monitored very closely.

Please make a note to see if you are currently taking any controlled substances.

TO OBTAIN REFILLS for these medications you MUST BE SEEN in the office every 3 months and must check the quantity before leaving the office.

Examples of controlled substances are:

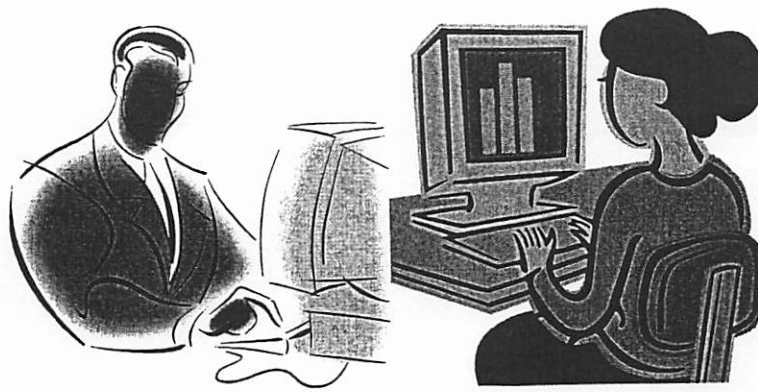
CONCERTA	AMBIEN	BELVIQ	CLONAZEPAM
QSYMIA	LYRICA	PERCOCET	PERCODAN
TRAMADOL	VICODIN	VYVANSE	ADDERALL
XANAX	ATIVAN		

Please make sure you obtain your refill during your office visit. We cannot fax these prescriptions.

If you do not comply with every 3-month med review policy, we will not be able to refill these medications. There will be no exceptions.

*The DEA (Drug Enforcement Agency) is mandating that all patients on controlled substances be evaluated in the office when given their prescriptions.

(Patient Copy)



Patient Portal

The Patient Portal provides patients and their families with access to their health information online at any time and from almost anywhere.

Step 1: Make sure we have your email address so we can web-enable your account

Step 2: Look for your Welcome Letter from Bhargesh P. Mehta M.D., P.A

Step 3: Click on the link provided and follow the prompts.

Step 4: Save this email for easy access to the Patient Portal

Patients can also access the Patient Portal by going to **Healow.com** or by downloading the **Healow app** or the **Healow Kids app (great app for parents with little ones)** Our practice code is **IFFHBA**