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PATIENT INFORMATION

Last Name: _____First: _____M.I: _____

Address:_____

City: _____State: _____Zip: _____Marital Status: S M D W Sex: ___

Home Phone #: _____Cell Phone #: _____

Race/Ethnicity: _____Date of Birth: _____SS #: _____

Email Address: _____May send information here? Yes No

Employer Name:_____
Occupation: _____Employment Status: Full time / Part time / Student

May we leave a message at your home? Yes No

Referred to this office by:

_____
Primary Care Physician:

_____

In case of emergency contact: _____Relationship: _____

Home Phone: ( ) _____Cell Phone: ( ) _____

Email Address: _____May send information here? Yes No

PHARMACY (Name, Address, Phone Number)

Responsible Party Information

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____Relationship:_____
Home Address: _____
Cell Phone: ( ) _____
Email Address:_____May send information here? Yes No

We ask that all payors keep a credit card on file for authorized services. However, you will always have the opportunity to use an alternate form of payment prior to the service date.

Credit/Debit Card Number:_____

Exp. Date:_____

* *
* *

CURRENT MEDICATIONS:

Prescription Medications

1. ______________________________dosage __________directions ________________

2. ______________________________dosage __________directions ________________

3. ______________________________dosage __________directions ________________

4. ______________________________dosage __________directions ________________

5. ______________________________dosage __________directions ________________

6. ______________________________dosage __________directions ________________

7. ______________________________dosage __________directions ________________

8. ______________________________dosage __________directions ________________

9. ______________________________dosage __________directions ________________

Over-the-Counter Medications:
1. ___________________
2. ___________________
3. ___________________

Allergies to Medications: ____

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* *

SOCIAL HISTORY:

Do you smoke? Yes / No   Date began to smoke? ______________How much? ______________

If you quit, quit date: __________/________/________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim.

Responsible Party Signature: ______________________________Date: ____________

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

1. CONSENT

I hereby give my consent for **Pooja Sharma, M.D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Pooja Sharma, M.D.** described such uses and discloses more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Pooja Sharma, M.D.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to N. Grattan, 9904 Clayton Road, Suite 135, St. Louis, MO 63124.

With this consent, **Pooja Sharma, M.D.,** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Pooja Sharma, M.D.,** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked "Personal and Confidential".

With this consent, **Pooja Sharma, M.D.** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Pooja Sharma, M.D.,** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Pooja Sharma, M.D.,** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Pooja Sharma, M.D.,** may decline to provide treatment to me.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize **Pooja Sharma, M.D.,** to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood product which may by administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration with the services provided to the patient by **Pooja Sharma, M.D.,** the undersigned agrees, whether he/she signs as patient or guarantor, to pay **Pooja Sharma, M.D.,** for all services ordered by the attending physician, or requested by the patient and/or the patient's family. **All requirements for referral, second opinion or pre-certification of care, policy exclusion or unmet pre-existing condition waiting period as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.**

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by **Pooja Sharma, M.D.,** I authorize direct payment to all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me.

5. OUT OF NETWORK COVERAGE

In accordance with the above terms and in consideration of the services provided to the above-named patient by **Pooja Sharma, M.D.,** the undersigned agrees, whether he/she signs as patient or guarantor, to pay **Pooja Sharma, M.D.,** for all services ordered by the attending physician, or requested by the patient and/or the patient's family.

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by **Pooja Sharma, M.D.,** the patient and/or guarantor will be personally responsible for all charges incurred.

6. DISABILITY AND/OR FMLA PAPERWORK

Please be aware that our office will charge for completing any type of disability and/or FMLA paperwork for either your insurance company and/or employer. Payment for such service is requested in advance.

7. MISSED APPOINTMENT POLICY

Our office will make every effort to see you promptly when you need to be seen, to not overbook appointments, and to keep wait time to a minimum.

As a courtesy, we will also make a reminder call/text to confirm your appointment, unless you ask us not to.

Please be advised that there will be a $100.00 cancellation fee for the first missed appointment or appointment canceled with less than 24 hours notice. There will be a $100 fee for repeated missed appointments or appointments canceled with less than 24 hours thereafter.

This fee must be paid prior to scheduling a new appointment.

HIPPA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used and shared. I acknowledge that Pooja Sharma, M.D., and staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Pooja Sharma, M.D., operation and responsibilities.

Initial of patient or person authorized to sign HIPAA Notice for Patient _____

Signed By: _____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Print Patient's Name Print Name of Legal Guardian, if applicable