Dr. Yamuna Gurrapu

North Texas Medical Clinic

PATIENT DEMOGRAPHICS

Date____/_____/_____

Patient Name: _____

DOB:_____Sex: M or F

Address:_____City:_____State:_____Zip Code: _____

Home phone #: _____ Mobile #: _____

Work #: _____

Email:_____

Marital Status: _____

Referred by:

- ☐ Friend/ Family Member _____
- ☐ Physician/Provider _____
- ☐ Advertisement _____
- ☐ Hospital _____

Primary Insurance: _____

Secondary Insurance: _____

Policy Holder Name: _____ DOB: _____

ID#_____ Group# _____

Employment Status: Full-Time / Part-Time / Retired / Student / Not Employed

Employer: _____

Phone #: _____

Emergency Contact:_____Relationship:_____Phone #: _____

Preferred Pharmacy:_____City:_____Phone #: _____

Pharmacy Intersection: _____

Patient Preference Regarding Communication of Health Information

Who to Contact: I hereby give my permission to Dr. Chintala and Dr. Gurrapu to disclose and discuss information related to my medical condition(s) to/with the following family members, other relatives, and/or close personal friends:

Name:_____

Relationship:_____

Name:_____

Relationship: _____

_____I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact: I wish to be contacted in the following manner:

Home Phone: **Work Phone:** **Mobile Phone:**

( ) OK to leave a detailed message. ( ) OK to leave a detailed message. ( ) OK to leave a detailed message.

( ) Leave message with call-back number only. ( ) Leave message with call-back number only.

( ) Leave message with call-back number only.

Written Communication:
( ) OK to mail to my home address:_____
( ) OK to mail to my office/work address:_____
( ) OK to fax to this number:_____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical records.

Signature of Patient or Legal Representative:

_____ Date: _____

Dr.Yamuna Gurrapu North Texas Medical Clinic P 469.294.9999 F 877.919.5871 www.ntm360.com

Patient Name: _____ **DOB**: _____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfil the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfil the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to North Texas Medical Clinic and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint North Texas Medical Clinic to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to North Texas Medical Clinic. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

Release of Information

Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Office Policies

I have read and received a copy of the office policies for North Texas Medical Clinic.

Payment Policies

I have read and received a copy of the payment policies for North Texas Medical Clinic.

Acknowledgement of Receipt of the Notice of Health Information Practices for North Texas Medical Clinic:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. North Texas Medical Clinic and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of North Texas Medical Clinics' Notice of Health Information Practices.

I have read all of the above and agree to these terms.

Signature of Patient/ Legal Guardian (if patient is a minor) **Date**