# FAMILY HEALTH & BEAUTY CENTER

**Patient Name:** _____ **Date of Birth:** _____

**SSN#** _____-_____-_____ **(Required)** **Gender:** Male_____ Female_____

**Marital Status:** Single / Married / Separated / Divorced / Widowed

**Street Address:** _____ **City**_____

**State** _____ **Zip**_____ **Email:** _____

**Best contact Ph#** _____**H/O/C** **Alternate number** _____**H/O/C**

**How did your hear about our practice?** _____

***IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?***
***Y_____ N_____ IF YES, PLEASE NOTIFY THE RECEPTIONIST***

**Please Note: All contact information provided above should be YOUR direct line of contact. To provide additional point of contacts for yourself, please ask for a "Patient Point of Contacts" Form.**

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**I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/ MEDICAL BENEFITS TO DR. PATEL FOR SERVICE RENDRED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY INSURANCE. ALSO, I HEREBY AUTHORIZE DR. PATEL TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I UNDERSTAND THAT IF PAYMENT IS NOT MADE IN A TIMELY MANNER I MAY INCUR LATE AND OR COLLECTION FEES ON ALL OVERDUE BALANCES ON MY ACCOUNT.**

_____

***Signature of Patient/ Responsible Party*** ***Date***

# Family Health & Beauty Center

## OFFICE POLICY REGARDING BILLING & INSURANCE

You are required to sign the assignment of insurance benefits claim before your initial visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete and correct proof of insurance prior to visit. Your insurance policy is a contract between you and your insurance company. We are not a party in this contract. If your insurance has not paid your account in full within 60 days, the balance can be considered your responsibility. Please be aware that some and perhaps all of services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

**IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INSURANCE POLICY COVERAGE ON VISIT, LABS/TESTS, REFERRALS, AND MEDICATIONS.**

**REGARDING INSURANCE PLANS WHERE WE ARE PARTICIPATING PROVIDERS: ALL CO-PAYS AND DEDUCTIBLES ARE DUE PRIOR TO TREATMENT.**

### Person responsible for Bill or Parent (complete only if different from patient)

**Guarantor Name:** _____ **SSN #** _____-_____-_____
**Relationship to Patient (please check) ( ) self, ( ) spouse, or ( ) Parent**
**Date of Birth:** ____/____/____ **Phone Number:** _____
**Address:** _____

### Primary Insurance Information

**Company name:** _____ **I.D. #** _____
**Policy Holder Name:** _____ **Policy Holder SSN#** _____-_____-_____
**Policy Holder Date of Birth** _____/_____/_____ **Gender: M / F**

### Secondary Insurance Information

**Company name:** _____ **I.D. #** _____
**Policy Holder Name:** _____ **Policy Holder SSN#** _____-_____-_____
**Policy Holder Date of Birth** _____/_____/_____ **Gender: M / F**

_____

*Signature of Patient/ Responsible Party* *Date*

## FAMILY HEALTH & BEAUTY CENTER OFFICE POLICY CONTINUED
**Please READ CAREFULLY before signing.**

### Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### Missed Appointments
Unless cancelled **at least 24 hours** in advance, there will be a **$50 missed appointment fee** payable prior to making the next appointment. A message may be left on our voicemail, which is checked at the start of each working day.

### Request for Medical Records, Paperwork, and Prescriptions
We need at least **48 to 72 hours** to process all request for records, paperwork, and prescriptions. Medical record requests will be handled in the order in which they are received/paid. The charge is $22.00 prep fee + $0.70 per page + postage.

### Returned Checks
All returned checks result in a $30.00 fee. If patient bounces one check, we reserve the right to not accept their checks anymore; payment must be made by cash or credit/debit card.

### Forms/Letters
It is required to schedule an appointment with Dr. Patel for completion of any forms/documents that require his signature.

### Interest
We reserve the right to charge interest in the amount of 1.5% per month as provided by state law.

### Doctor's Right to Terminate Medical Services
Dr. Patel has the right to terminate the doctor/patient relationship for consistently missed scheduled appointments, refusal to pay outstanding balances, refusal to follow doctor's orders/treatments, or for inappropriate and disrespectful behavior towards the doctor, staff, or other patients.

### Lost Items
Our office is not responsible for any items that are left behind in the examination room or waiting area.

I HAVE READ THE FINANCIAL AND OFFICE POLICY AND AM AWARE OF ITS LEGALITY. I UNDERSTAND AND AGREE TO ALL OF THE ABOVE POLICIES.

*Signature of Patient/ Responsible Party* *Date*

# Family Health & Beauty Center

## NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 196 ("HIPA") is a Federal program that request that medical records and other individually identifiable health information used or disclosed by using any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right of understand and control how your personal health information ("PHI") is used. HIPA provides penalties for covered entries the misuse personal health information.

As required by HIPA, we prepared this explanation of how e are to maintain the privacy of your health information and how email disclose your personal information.

We may use disclose your records only for each of the following purpose: treatment, Payment and health care operation.

- Treatment means providing, coordinate, or managing health care and related services by one or more healthcare providers. An example of this would include referring you the retina specialist.
- Payment means such actives a obtain reimbursement for services, confirming coverage, billing or collections actives, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to any services offered.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving actives, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best assure its continued confidentially to the extend possible.

We may contact you, by phone, or by writing email, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, the may be of interest you. You do have the right "opt out" with respect o receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant our receiving a written authorization from you:

- Most use and disclosure of psychotherapy notes;
- Use and disclosure of your PHI for marketing purpose, including subsidized treatment and health care operations;
- Disclosures the constitute a sale of PHI under HIPA; and
- Other use and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extend that we have already taken actions relying on your authorization.

You may have the following rights with respect your PHI.

- The right to request restrictions on certain use and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances whic we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right or reasonable request or receive confidential communications of Protected Health Information by alterative means or alternative locations.
- The right to inspect and copy our PHI.
- The right to amend your PHI.
- The right or receive accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request hat we not disclose PHI related solely to those services to a health plan, well accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protect Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of September 23, 2013 and its our intention to abide by the terms of the Notice of Privacy Practices and HIPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.
You have recourse if you fell that your protections have been violated by our office. You have the right of file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing complaint.

I _____ patient of Family Health & Beauty Center acknowledge receipt of notice of privacy practices.

_____ _____

Signature Date


# Missed Appointment Policy

We appreciate your choosing our office for your medical and/or cosmetic needs.

If you are unable to keep your appointment, we ask that you provide us with at least 24 hours notice. Your courtesy makes it possible for us to give your appointment o another patient. If you fail to cancel your appointment 24 hours ahead of the scheduled time (or by non on Friday for Monday appointments), we will bill $50 to your account.

Thank you.

_____ _____

Please Print Name Date

_____

Signature

ALKESH D. PATEL, M.D.
Family Health Center

## CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful, but have high potential misuse and are, therefore, closely controlled by the local, state and federal government. They are intended to relieve pain and improve function and/or ability to work, not simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it sooner than prescribed, I understand that it will not be replaced.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Patel. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.

3. I will use the prescribed medication for as instructed on the prescription and will not divert (give), trade or sell or attempt to sell the medication to anyone else.

4. Refills of controlled substance medication:

    a. will be made only during Dr. Patel's regular office hours, not at night, on holidays or weekends.
    b. will not be made if "I run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c. will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least forty-eight(48) hours ahead if I need assistance with a controlled substance medication prescription.

5. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment by Dr. Patel may be ended immediately. If the violation involves obtaining controlled substances from another individual, I understand that I may also be reported to the legal authorities.



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6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health care habits: exercise, weight control and not using tobacco or alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome of my treatment.

I have been fully informed by Dr. Patel and his staff regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some persons may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependant on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under the medical supervision or I may have withdrawal symptoms.

I have read this contract and it has been explained to me by Dr. Patel and/or his staff. In addition, I fully understand the consequences of violating this contract.

_____

Patient's Name Patient's Signature Date

_____ _____

Witness Date

**REQUIRED: NAME AND TELEPHONE NUMBER OF THE PREVIOUSLY PRESCRIBING PHYSICIAN**

_____ _____

Physician's Name Telephone Number



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