The Office of Madhu R. Agarwal, M.D

PATIENT REGISTRATION INFORMATION: PLEASE COMPLETE ALL SECTIONS

First Name:________________________Middle:___________Last Name:__________________Sex: M F
Birth date:________________________________Soc. Sec #:____
Address:________________________________City/State/Zip:____
Home Telephone:_________________Cell phone:___________________Email:_________________________
Patient Employer:____
Occupation/Title:____Work Phone: ______________________
For appointment reminders or call back request or information regarding your health, OK to leave messages on answering machine or text? Yes No
Is it OK to leave messages with family members? Yes No

SPOUSE/PARENT INFORMATION

Name:____Birth date:______________________
Soc.Sec #:____Sex: M F
Address if different than above:____
Home Telephone: (_______)_________________________Cell phone:(_______)________________________

EMERGENCY CONTACT INFORMATION

Name:____________ _____________ Relationship: ____________________________________
Address:____
Home Telephone: (______)______________________ Cell Phone: (____)__________________________

PLEASE LIST ALL THE DOCTORS WHO CARE FOR YOU

Provider's Name:_____________________Specialty_______________Contact Phone (____) ________________
Provider's Name:_____________________Specialty_______________Contact Phone (____) ________________
Provider's Name:_____________________ Specialty_______________Contact Phone (____) ________________
Provider's Name:_____________________Specialty________________Contact Phone (_____) _______________

Recent Hospital Visit:

Allergies To Medication:

MRI / CT/ LABS (Please Circle) **Location/Date done:**

Past Surgeries:

Medical Problems: (Circle) Diabetes High Blood Pressure Cholesterol Cancer Head Trauma

PLEASE LIST OTHER MEDICAL PROBLEMS BELOW: ______________________________________
FAMILY HISTORY:____
Marital Status: Married Single Divorced Separated Widowed
Do you smoke? Yes No
Do you drink alcohol: Yes No

I hereby grant permission to The Office to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to The office of Madhu R. Agarwal MD

_______________________________________ ____________________
Signature of Patient (Parent if Patient is minor) Date

The Office of: Madhu R. Agarwal, M.D.

FINANCIAL POLICIES

Copayment and deductible payments as determined by your agreement with your insurance carrier are **due at the time of service.** We will file your insurance claim if you agree to have your insurance company pay the doctor directly for services provided. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for payment. **YOUR CHARGES MAY BE $500 (ESTIMATED AMOUNT) WHICH MAY NOT BE COVERED BY INSURANCE.** Payment is due upon receipt of a statement from our office.

If you have no health insurance, payment is due at the time of service.

In consideration to other patients and the physician, we request 24 hours notice to cancel an appointment. You may be charged $25 for a missed appointment. Missing more than two appointments without providing notice are grounds for discharge from the practice.

I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release information necessary to secure the payment of benefits from my insurance company.

CREDIT CARD AUTHORIZATION: I acknowledge and authorize The Office to charge my credit card on file for any co-payment, co-insurance, deductible and/or charges not covered by health insurance provider. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account with the office.

AUTHORIZATION REQUIREMENT

I am seeking treatment from The Office of Madhu Agarwal MD and understand that *if* my medical insurance company requires an authorization to see a specialist, I am responsible for ensuring that the authorization has taken place. If I have not obtained a required authorization at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by my insurance company.

NOTICE OF PRIVACY PRACTICES

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPAA"),** I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).

2. To obtain payment from third party payers (insurance, etc.)

3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I have been informed by The Office of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

INFORMATION ABOUT DILATING YOUR EYES

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because dilating drops may make driving difficult, it is best that you not drive after dilation for at least 4 hours. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and agree to the above policies:

____
Signature

____________________ ____________________
Print Name Date