NIBHA MEDIRATTA, M.D.
1970 HOSPITAL VIEW WAY UNIT 1
CLERMONT, FL 34711
PH: 352-243-1101 • FAX: 352-243-1134

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	M.I.	GENDER ☐MALE ☐FEMALE	DATE OF BIRTH

PRIMARY ADDRESS	CITY	STATE	ZIP
ALTERNATIVE ADDRESS (IF APPLICABLE)	**CITY**	**STATE**	**ZIP**

MARITAL STATUS	WORK STATUS	SOCIAL SECURITY #:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ STUDENT	
PRIMARY PHONE #	**SECONDARY PHONE #**	**EMAIL ADDRESS**

PLACE OF EMPLOYMENT	WORK PHONE	EXT	REFERRED BY

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

RACE ☐ DECLINE TO PROVIDE INFORMATION
☐ WHITE ☐ AFRICAN AMERICAN ☐ HISPANIC
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ ASIAN
☐ AMERICAN INDIAN OR ALASKA NATIVE

ETHNICITY ☐ DECLINE TO PROVIDE INFORMATION
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

PREFERRED LANGUAGE:
☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

PRIMARY INSURANCE (CARD WILL BE SCANNED)		SECONDARY INSURANCE (CARD WILL BE SCANNED)	
NAME OF POLICY HOLDER		**NAME OF POLICY HOLDER**	
DATE OF BIRTH	**SOCIAL SECURITY #**	**DATE OF BIRTH**	**SOCIAL SECURITY #**

RELATIONSHIP TO POLICY HOLDER
☐ SELF ☐ SPOUSE
☐ CHILD ☐ OTHER:_____

RELATIONSHIP TO POLICY HOLDER
☐ SELF ☐ SPOUSE
☐ CHILD ☐ OTHER:_____

AUTHORIZATION

I AUTHORIZE THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY INSURANCE CHANGES OR PLAN UPDATES AND TO SUBMIT TO THEM MY INSURANCE CARDS FOR COPYING. I UNDERSTAND IT IS ALSO MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY NAME CHANGES AND ADDRESS CHANGES OR UPDATES.

_____ _____
SIGNATURE OF __PATIENT__PERSONAL REPRESENTATIVE* DATE

_____ _____
PRINTED NAME *IF PERSONAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

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OFFICE AND FINANCIAL POLICIES

PLEASE READ AND INITIAL OUR OFFICE AND FINANCIAL POLICIES AND SIGN BELOW.

- ANY FORMS THAT NEED TO BE COMPLETED REQUIRING THE DOCTOR'S SIGNATURE(S) AND EXTENSIVE REVIEW OF THE MEDICAL RECORD WILL RESULT IN A $35.00 CHARGE (EXAMPLES: FMLA PAPERWORK & DISABILITY FORMS). _____INITIAL

- IF YOU NEED **PRINTED** COPIES OF YOUR MEDICAL RECORDS FOR YOUR **PERSONAL USE**, WE WILL NEED A TWO WEEK NOTICE. THERE WILL BE A CHARGE OF $1.00 PER PAGE FOR THE FIRST 25 PAGES AND $0.25 PER PAGE THEREAFTER. THERE WILL BE NO CHARGE FOR MEDICAL RECORDS IF ANOTHER PHYSICIAN OR MEDICAL FACILITY IS REQUESTING THEM. _____INITIAL

- THERE WILL BE A $25.00 CHARGE FOR ALL RETURNED, INSUFFICIENT FUND CHECKS OR STOP PAYMENT CHECKS AND YOU WILL BE REQUIRED TO PAY CASH OR CREDIT CARD ON ALL FUTURE VISITS. _____INITIAL

- ALL PATIENTS REQUIRING NON-EMERGENCY APPOINTMENTS WILL BE GIVEN AN APPOINTMENT WITHIN 2 WEEKS OF THEIR REQUEST. EMERGENCY APPOINTMENTS WILL BE WORKED IN THE SAME DAY. _____INITIAL

- YOUR INSURANCE COMPANY REQUIRES US TO COLLECT CO-PAYMENTS AT THE TIME OF SERVICE. WAIVER OF CO-PAYMENTS MAY CONSTITUTE FRAUD UNDER STATE AND FEDERAL LAW. TO REMAIN COMPLIANT, WE COLLECT YOUR CO-PAYMENT AT EACH VISIT. _____INITIAL

- ALL PATIENTS WHO DO NOT CONTACT THE OFFICE TO CANCEL OR RESCHEDULE THEIR APPOINTMENT 24 HOURS PRIOR TO THEIR APPOINTMENT TIME WILL BE CHARGED A $50.00 FEE. IF THERE ARE THREE (3) MISSED APPOINTMENTS WITHOUT PRIOR NOTIFICATION, IT WILL RESULT IN THE IMMEDIATE DISMISSAL FROM OUR PRACTICE. _____INITIAL

- WE USE DIAGNOSIS CODES ON YOUR LAB REQUEST TO THE BEST OF OUR KNOWLEDGE AND ACCURACY, HOWEVER, OUR OFFICE ***WILL NOT*** BE RESPONSIBLE FOR ANY BILL THAT MAY BE INCURRED BY THE INSURANCE OR LAB COMPANY. _____INITIAL

- IF YOU HAVE NOT HAD A VISIT WITH ANY OF OUR PROVIDERS IN OVER 2 YEARS, YOUR ACCOUNT WILL BECOME INACTIVE. IF YOU REQUEST TO RE-ESTABLISH WITH OUR PRACTICE, YOU WILL BE CONSIDERED A NEW PATIENT AND THE CURRENT POLICY FOR NEW PATIENT ACCEPTANCE WILL APPLY. _____INITIAL

- WE ***DO NOT*** ALLOW THE RE-ESTABLISHMENT OF A PATIENT ONCE THEY HAVE TRANSFERRED CARE TO ANOTHER PRIMARY CARE PHYSICIAN FOR ANY REASON OTHER THAN CHANGE OF INSURANCE OR DUE TO RELOCATION. _____INITIAL

- EMERGENCY ROOM UTILIZATION – OUR OFFICE OFFERS 24/7 TELEPHONE AND SAME DAY APPOINTMENTS. FOR NON LIFE-THREATENING ISSUES, PLEASE CONTACT OUR OFFICE FIRST BEFORE GOING TO THE EMERGENCY ROOM. FAILURE TO DO SO COULD RESULT IN BEING DISCHARGED FROM OUR PRACTICE.

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE **OFFICE AND FINANCIAL POLICIES.** I RECOGNIZE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. BY SIGNING THIS FORM, I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED FEES.

_____ _____

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE) DATE

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POLICIES EFFECTIVE 12/2015

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU READ AND UNDERSTAND THE FOLLOWING:

I AUTHORIZE NIBHA MEDIRATTA, MD PL AND THEIR PROVIDERS TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA RXHUB PRESCRIPTION SERVICE. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE OTHER UNAFFILIATED MEDICAL PROVIDERS, INSURANCE COMPANIES, AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY MY PROVIDERS AND OFFICE STAFF, AND IT MAY INCLUDE PAST PRESCRIPTIONS FROM SEVERAL YEARS AGO. I UNDERSTAND THIS WILL ALLOW MY PROVIDERS TO BETTER COORDINATE MY CARE AND MEDICATION HISTORY TO MAXIMIZE THE EFFECTIVENESS AND SAFETY OF MY TREATMENT PLAN.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* DATE

PRINTED NAME *IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT

PREFERRED PHARMACY:

NAME: _____

LOCATION: _____

PHONE #: _____

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POLICIES EFFECTIVE 12/2015

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES

THE PATIENT HEREBY CONSENTS TO THE USE OR DISCLOSURE OF HIS/HER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("PROTECTED HEALTH INFORMATION") AND PATIENT MEDICAL RECORD INFORMATION BY **NIBHA MEDIRATTA, M.D.** IN ORDER TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PATIENT SHOULD REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF THE POTENTIAL USES AND DISCLOSURES OF SUCH INFORMATION, AND THE PATIENT HAS THE RIGHT TO REVIEW SUCH NOTICE PRIOR TO SIGNING THIS CONSENT FORM.

THE PRACTICE RESERVES FOR ITSELF THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. IF THE PRACTICE DOES CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, PATIENT MAY OBTAIN A COPY OF THE REVISED NOTICE IN THE OFFICE OR BY SENDING A WRITTEN REQUEST TO **NIBHA MEDIRATTA, M.D., 1970 HOSPITAL VIEW WAY, UNIT 1, CLERMONT, FL 34711.**

PATIENT RETAINS THE RIGHT TO REQUEST THAT THE PRACTICE FURTHER RESTRICT HOW HIS/HER PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PRACTICE IS NOT REQUIRED TO AGREE TO SUCH REQUESTED RESTRICTIONS; HOWEVER, IF THE PRACTICE DOES AGREE TO PATIENT'S REQUESTED RESTRICTION(S), SUCH RESTRICTIONS ARE THEN BINDING ON THE PRACTICE.

PATIENT ACKNOWLEDGES AND AGREES THAT THE PRACTICE MAY DISCLOSE PATIENT'S PROTECTED HEALTH INFORMATION AND PATIENT MEDICAL RECORD INFORMATION TO THE FOLLOWING INDIVIDUALS WHO ARE EITHER THE PATIENT'S FAMILY MEMBERS, LEGAL REPRESENTATIVES, GUARDIANS, HEALTH CARE SURROGATES, OR HAVE POWER OF ATTORNEY ON BEHALF OF THE PATIENT:

WITH THIS CONSENT, NIBHA MEDIRATTA, MD, PL OR THEIR PROVIDERS MAY DISCUSS MY MEDICAL INFORMATION WITH:

NAME:_____ RELATIONSHIP:_____ PHONE #:_____

NAME:_____ RELATIONSHIP:_____ PHONE #:_____

NAME:_____ RELATIONSHIP:_____ PHONE #:_____

THE PATIENT AGREES THAT THE PRACTICE MAY DISCLOSE THE FOLLOWING TYPES OF INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORDS (PLEASE **INITIAL** THE APPROPRIATE CATEGORIES LISTED BELOW):

____ HIV/AIDS INFORMATION

____ MENTAL HEALTH INFORMATION

____ SUBSTANCE ABUSE INFORMATION

____ SEXUALLY TRANSMITTED DISEASE INFORMATION

PATIENT AGREES AND CONSENTS TO THE PRACTICE RELEASING INFORMATION TO PATIENT IN THE FOLLOWING ALTERNATIVE MANNERS (PLEASE **INITIAL** THE APPROPRIATE SPACES BELOW):

____ VIA E-MAIL TO THE PATIENT'S DESIGNATED E-MAIL ADDRESS WHICH IS:

_____.

VIA REGULAR MAIL WITH ANY ENVELOPES BEING MARKED PERSONAL AND

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CONFIDENTIAL AND ADDRESSED TO PATIENT.

____ VIA TELEPHONE, IF PATIENT CONTACTS THE PRACTICE AND PROVIDES THE APPROPRIATE INFORMATION (INCLUDING THE PATIENT'S NAME, SOCIAL SECURITY NUMBER AND UNIQUE PERSONAL IDENTIFIER).

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

AT ALL TIMES, PATIENT RETAINS THE RIGHT TO REVOKE THIS CONSENT. SUCH REVOCATION MUST BE SUBMITTED TO THE PRACTICE IN WRITING. THE REVOCATION SHALL BE EFFECTIVE *EXCEPT* TO THE EXTENT THAT THE PRACTICE HAS ALREADY TAKEN ACTION IN RELIANCE ON THE CONSENT.

THE PRACTICE MAY REFUSE TO TREAT PATIENT IF HE/SHE (OR AN AUTHORIZED REPRESENTATIVE) DOES NOT SIGN THIS CONSENT FORM. IF PATIENT (OR AUTHORIZED REPRESENTATIVE) SIGNS THIS CONSENT AND THEN REVOKES IT, THE PRACTICE HAS THE RIGHT TO REFUSE TO PROVIDE FURTHER TREATMENT TO PATIENT AS OF THE TIME OF REVOCATION (EXCEPT TO THE EXTENT THAT THE PRACTICE IS REQUIRED BY LAW TO TREAT INDIVIDUALS).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE, *IF REQUESTED*, RECEIVED A PAPER COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____

SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* DATE

_____ _____

PRINTED NAME *IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT

*PLEASE EXPLAIN REPRESENTATIVE'S RELATIONSHIP TO PATIENT AND INCLUDE A DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT:

_____

_____

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EMERGENCY ROOM UTILIZATION CONTRACT

Your healthcare is very important to us. Our office offers 24/7 telephone access and same day appointments as a way to ensure that our patients have access to their provider when it is needed and also to avoid unnecessary medical expenses.

For non-life-threatening medical issues, we ask that our patients contact our office first before proceeding to an urgent care or emergency room. Upon receiving your call, the office will assess the urgency of the issue and schedule an appointment accordingly. If you experience a non-life-threating medical issue *after hours*, please call our office phone number and follow the prompts to be routed to the on-call provider. The provider should return your call within the hour.

The attached document provides examples of medical issues that are best treated by the ER or by your Primary Care Physician (PCP). Understand, that if you are unsure of what you should do, please call your doctor. Your doctor will be able to tell you whether you should go to the ER or if it san issue that can be treated over the phone or in the office.

In the even that you are required to receive medial care at an urgent care of hospital, please inform the facility that you are a patient of Dr. Nibha Mediratta and sign a release to have your records sent to our office. Our office fax number is 352-243-1134. It is important that the records from your visit are sent to our office to allow Dr. Mediratta to appropriately coordinate your care

Please sign below to confirm that you understand this policy.

- I understand that I should go the emergency room in the event of a life-threatening medical issue.
- I understand, for all non-life-threatening medical issues that occur during or after regular business hours, I should call my doctor's office before going to an urgent care or emergency room.

Printed Name: _____

Signaure: _____

Date: _____

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REASONS TO USE THE EMERGENCY ROOM

- Uncontrolled bleeding
- Chest pain or pressure
- Vomiting blood
- Mental status change
- Sudden onset of severe pain
- Sudden onset of vision changes, dizziness, or weakness
- Complex fractures

Reasons To Call Your Doctor First

- Cuts, sprains, insect bites
- Flare ups of chronic conditions
- Asthma
- Flu/Respiratory infections
- Fever
- Simple Fractures
- Urinary tract infection