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 □ SINGLE □ MARRIED □ DIVORCED □ OTHER	**WORK STATUS** □ EMPLOYED □ RETIRED □ UNEMPLOYED □ STUDENT		**SOCIAL SECURITY #:**	
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

POLICIES EFFECTIVE 12/2015

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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**

- ALL SELF-PAY PATIENTS WILL BE EXPECTED TO PAY THE FULL PAYMENT ON THE DATE OF SERVICE. THE CURRENT SELF PAY PRICE IS $100 FOR A FOLLOW UP VISIT. **_____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 $25.00 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**

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

NIBHA MEDIRATTA, M.D.
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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 #: _____

POLICIES EFFECTIVE 12/2015

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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 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).

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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:

_____

_____