Dr. Pridhvi Yelamanchili

Patient Registration Form

Name: ____ Date of Birth:___/___/_____

SS #: _____-________-________ SEX: (M/F) Marital Status: (S/M/W/D)

Mailing Address:____________________________ City: ________ State: _______ Zip Code _______

Phone 1: ( )____________________ Phone 2: ( )____________________

Employer: ____

Race: ________________ Ethnicity:________________ Language Spoken:_______________________

Referred By: ____ Phone #: ( ) ___________________

Primary Care Physician: ________________________________ Phone #: ( ) ___________________

Pharmacy: ____

Who may receive information regarding your Protected Health Information?

Name: **Relation:** **Phone #**

1. ______________________ ____________________ ______________________

2.______________________ ____________________ ______________________

Insurance Information

Primary Insurance:____

ID #: _______________________________ Group #: ________________

Secondary Insurance: ____

ID #: _______________________________ Group #: ________________

I gave a copy of my primary insurance Card (Y)/(N) and secondary insurance Card (Y)/(N) *(if applicable)*

May we leave a message on your answering machine? (Y/N

Consent to Obtain Prescription History:

I give my consent to obtain any and all records pertaining to my prescription history: INITIAL and DATE__________________

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider. **INITIAL and DATE_________________**

Authorization & Assignment

I hereby authorize Arizona Heart Doctor, PLLC to release any medication information that may be necessary for either medical care or in processing applications for financial benefits. I hereby authorize direct payment of medical benefits to Arizona Heart Doctor, PLLC, for services rendered. I understand that I am financially responsible for any balances not covered by my insurance. I agree to pay my copayments at time of service.

PATIENT SIGNATURE: ________________________________ DATE: __________________

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Policy and Procedures

We would like to take this opportunity to welcome you to our office. The following document will outline our policies and procedures relating to our financial policy. Please take some time and read this document.

Healthcare Requirements:

The clinic specializes in your complete Cardiovascular Care, including diagnosis and treatment of various cardiac medical conditions. We believe in providing you with the best possible care and working as a team with your family physician, internists, other cardiologists and/or any other specialists to help you with the latest care in healthy living.

PAYMENT AT THE TIME OF SERVICE IS RENDERED: Initials ____________

Payment is required at the time services are rendered. We would appreciate your co-pays, deductibles, and/or patient non-insured portion at the time of the visits, if we participate with your insurance plan. This policy allows us to balance your account to zero when the insurance check arrives and saves you from receiving numerous monthly statements. We accept cash, personal checks, and MasterCard or Visa. For all returned checks and additional $25 fee will be assessed and incurred by the writer per check.

BILLING PROCEDURES: Initials ____________

As you visit our office requesting medical care, you undertake a personal obligation and responsibility for your account. All statements are mailed out monthly. We ask that you pay balances off monthly (unless other arrangements have been made), and we regard any account over 90 days old as a matter of collection.

COLLECTION PROCESS: Initials ____________

If any document does advance to collection and/or litigation, the patient is financially responsible for all costs that might be incurred in collection said account, i.e. attorney fees, court costs, filing fees, etc.

INSURANCE REFERRALS: Initials ____________

For any contracted insurance plans that require a referral form, we must ask that the referral form be brought in with you at the time of the appointment. We will not await the referral by mail. If we do not have the valid referral at the time of your appointment, your appointment will be rescheduled and/or cancelled.

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ADDRESS AND INSURANCE CHANGES: Initials ____________

Please keep us informed and updated of contact information, employment, and/or insurance changes, and emergency contact.

INTEGRITY AGREEMENT: Initials ____________

Both parties desire to have a method of resolving discomfort, misunderstanding or disputes. If any of these previously mentioned occur, please bring it to our attention private, quickly, and in a friendly manner. We agree to resolve these matters using the communication, mediation, and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement. (This in no way relinquishes your possibilities of seeking legal counsel.)

SPECIAL NEEDS: Initials ____________

We are here to help you. If you have special needs or circumstances that may require a payment plan, please feel free to discuss this with us as early as possible.

CANCELLATION OF APPOINTMENTS: Initials ____________

We require a 24 hour cancellation notice of all scheduled appointments. Any appointments not cancelled within 24 hour time frame will be subjected to a cancellation fee.

PRIOR AUTHORIZATIONS/PATIENT COSTS: Initials ____________

We will seek prior authorization for all major procedures ordered by our office. When an insurance approves a procedure via a prior authorization, this means they will cover expenses according to your specific agreement between you and the insurance. There may still be a portion of a bill that your insurance will consider patient responsibility based on your ***specific*** coinsurance, deductible, copayment, etc. Since there are many insurance plans in existence which often times change year by year, please call customer service for your insurance if you have any questions on patient responsibility regarding costs for any studies our office has recommended.

Thank you for taking the time to read this policy and procedures statement. We hope that it answers any questions that you may have regarding the Institute's financial policies.

PATIENT'S DECLARATION:

I have read and understand this policy statement. I understand that I am financially responsible for charges incurred and I authorize my insurance carrier to pay benefits to AZ Heart Doctor, PLLC. All of my questions and concerns have been answered.

Signed by ______________________________ Signed by ______________________________

(Patient) (Guardian- if applicable)

Date: ________________

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Advance Directive

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. You can write an advance directive in several ways:

- Use a form if provided by your primary care doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized and copies should be given to your family and your doctor.

It is our policy to have each our patient's Advance Directives reviewed and noted in the chart annually. Please choose from the list below and check what pertains to you.

- ☐ Discussed- No decision made
- ☐ You have a Living Will on file
- ☐ Do Not Resuscitate- please provide a copy for us to have on file
- ☐ Power of Attorney- please provide a copy for us to have on file
- ☐ Specific Advance Directive- please provide a copy for us to have on file

____________________________ __________________
Patient Signature Date

____________________________ __________________
Witness Signature Date
(Employee of AZ Heart Doctor)

Dr. Pridhvi Yelamanchili

Records Release

Records from: ____

____

____

I hereby authorize: AZ Heart Doctor, PLLC

Copy or Summary of:

____

____

____

Concerning my illness and/or treatment during the period from:

______________________________ **to** ______________________________

Patient's Name (Print): ___________________________ **D.O.B:** _______________

Signature: ____________________________________ **Date:** _______________

Witness & Relationship of Witness:

____

Name (Print) **Signature** **Date**

***** This authorization will expire in 12 months from the date of this signature*****