Vijaya Nama, MD, PA
5115 North Galloway Ave. Suite 304
Mesquite, TX 75150
Tel: (972) 613-2127 Fax: (972) 613-2726

Patient Information

Last Name:_____ First Name:_____ M.I.:___ S.S.#:___-___-____ DOB: ___/___/___Sex___
Address:_____ Apt #:_____ City:_____ State:____ Zip:_____
Home Phone:(___)_____ Work Phone:(___)_____ Marital Status: S M D W O Occupation:_____
Employer:_____ Address:_____ Phone #:(___)_____
Primary Insured's Name:_____ S.S.#:___-___-____ DOB:_____
Spouse or Parent's Name:_____ S.S.#:___-___-____ Phone #:(___)_____
Address (if different from above):_____ City:_____ St:____ Zip:_____
Employer:_____ Address:_____ Phone #:(___)_____

Insurance Information

Medicare #:_____ Effective Date: _____ Date Applied: _____
Medicaid #:_____ Effective Date: _____ Date Applied: _____
Primary Insurance: _____ Group #: _____ ID #:_____
PCP Name:_____ Phone #:(___)_____
Secondary Insurance:_____ Group #:_____ Policy #:_____
Address:_____ Phone #:(___)_____
Name Insured:_____ Rel:_____ Type of Coverage:_____
Employer:_____ Address:_____

Emergency Contact Information

1):_____ Relationship:_____ Phone #:(___)_____
2):_____ Relationship:_____ Phone #:(___)_____

Referred by: _____ Phone #:(___)_____

Which category best describes your race?
[ ]American Indian or Alaska native [ ] Native Hawaiian or other pacific islander [ ] Black or Afrian American [ ] Multiracial

[ ] White [ ] Other [ ]Decline

Do you consider yourself Hispanic/Latino? [ ] yes [ ] no [ ] decline

What language do you feel most comfortable speaking with your doctor or staff?

[ ] English [ ] Spanish [ ] Indian [ ] Decline

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Vijaya Nama, MD, PA
5115 North Galloway Ave. Suite 302
Mesquite, TX 75150
Tel: (972) 613-2127 Fax: (972) 613-2726

1. INDIVIDUAL PATIENT

I give my authorization to use or disclose my protected health information as described in Section 2 below.

Your Name:_____ Social Security #:_____-_____-_____

Legal Responsibility

- ❑ If you are 18 years old or older, you are legally responsible for yourself, check this box.
- ❑ If you are an emancipated child or teenager and your parents no longer have custody over you, check here.
- ❑ If you are a child or teenager and your parents are divorced, please check this box. Below please list the names of the parent or guardian who has custody over you.

2. THE USE AND/OR DISCLOSURE

A. I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved wiht your insurance claims fulfillment.

B. Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, other family members, and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan, or payment.

Below, please list the people/organizations that you authorize to have access to your information:

Persons/Organizations Receiving the Information:

1) Name:_____ Contact Phone #:(_____)_____
Address:_____ Relationship:_____
What Specific Information to Disclose:_____
Date the Disclosure Will Expire:_____

2) Name:_____ Contact Phone #:(_____)_____
Address:_____ Relationship:_____
What Specific Information to Disclose:_____
Date the Disclosure Will Expire:_____

3. CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

4. METHOD OF CONTACT

I authorize the office of Vijaya Nama, MD, PA to contact me the following manner:

_____ Home Phone # :(_____) _____ _____ OK to leave a message with detailed information
_____ OK to mail my home address _____ Leave a message with a callback number only
_____ Work Phone # :(_____) _____

5. STATEMENT OF UNDERSTANDING

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of Vijaya Nama, MD, PA, who are part of the health care process. These business associates will also keep your health information

Assignment of Benefits Release of information Notice of Privacy Practices Appointment of Authorized Representative

Please read and initial each paragraph

_____Vijaya Nama, M.D., PA and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Vijaya Nama, M.D., PA for any services furnished to my by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____I appoint Vijaya Nama, M.D., PA to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____Unless I request to the contrary in writing, I will accept appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of this practice

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office, Vijaya Nama, M.D., PA.
- The remainder of your bill will be sent to your health plan for direct payment to our office
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, you agree to send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  1) This is a pre-existing illness that is not covered by your plan
  2) You have not met your full calendar year deductible
  3) The type of medical service required is not covered by your plan
  4) The health plan was not in effect at the time of service
  5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be excluded in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. However, we reserve the right to refuse service if you have an outstanding account balance that no payment has been arranged. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Signature: _____ Date _____

Patient Name:_____**Date:** _____

What is the reason for your visit? _____
_____
_____

What are your current symptoms (example: pain, numbness, etc...)? _____
_____
_____

Past Medical History
Please list all medical diagnosis and conditions:_____
_____
_____
_____

Past Surgical History
Have you had any prior surgeries?____Yes____No
Please list all surgeries you have had with the surgeon name:_____
_____
_____
_____

Social History
What is your occupation?_____Retired/Disabled
Who lives at home with you? _____

Do you smoke?____Yes____No Do you use illicit drugs?____Yes____No
Do you drink Alcohol?____Yes____No If yes how Frequent?_____

Family History

Relation to Patient	Are they living?	If deceased what was the cause death?	If deceased at what age did they pass?
Mother			
Father			
Sibling			
Sibling			
Sibling			

Please list any allergies to medications:_____
_____

Please list all your current medications, including strength and how often you take them:

Medication	Strength	Number of Times a Day
	mg	
	mg	
	mg	
	mg	
	mg	

Have you suffered from any of the following medical condition

Recent chills/ fever	Yes	No	Abdominal Pain	Yes	No
Recent bruising	Yes	No	Kidney problems	Yes	No
Recent Skin Rash	Yes	No	Infections in urine	Yes	No
Head aches	Yes	No	Blood in Urine	Yes	No
Visual disturbances	Yes	No	Connective tissue disorder	Yes	No
Neck pain	Yes	No	Back pain	Yes	No
Asthma	Yes	No	Joint pain	Yes	No
Bronchitis	Yes	No	Seizures	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Pneumonia	Yes	No	Dizziness	Yes	No
Shortness of Breath	Yes	No	Incontinence of Stool	Yes	No
Tuberculosis	Yes	No	Syncope	Yes	No
High Blood Pressure	Yes	No	Weakness in Extremities	Yes	No
Chest Pain	Yes	No	Psychiatric problems	Yes	No
Heart Attack	Yes	No	Anxiety	Yes	No
Circulatory problems	Yes	No	Depression	Yes	No
Palpitations	Yes	No	Diabetes	Yes	No
Swelling of Extremities	Yes	No	Thyroid problems	Yes	No
Gallbladder problems	Yes	No	Cancer	Yes	No
Peptic ulcer disease	Yes	No	Hepatitis	Yes	No
Blood in stools	Yes	No	Rheumatoid arthritis	Yes	No
Persistent black stools	Yes	No	Sexual Dysfunction	Yes	No
Recent Constipation	Yes	No	Unusual Bleeding	Yes	No
Resent Diarrhea	Yes	No	Blood clots	Yes	No

VIJAYA NAMA MD. PA

Patient Authorization & Consent

Dr. Vijaya Nama MD. PA is committed to fulfilling all the requirements of the Health Insurance Portability & Accountability Act (HIPAA) of 2004.

Section A: Authorization:

This must be completed for all authorizations. The patient or the patient's representative must read and initial the following statements:

1. I authorize Dr. Vaijaya Nama MD. PA to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

   Initials: _____

2. I understand that I may revoke this authorization any time by notifying Dr. Vijaya Nama MD. PA. But, if I revoke this authorization, my revocation will not have an effect on any actions Dr. Vijaya Nama MD PA took before they received my revocation.

   Initials: _____

   You may revoke this authorization by signing a Revocation Authorization form and returning it to Dr. Vijaya Nama MD PA. To request a Revocation Authorization form, you may ask the receptionist or contact our office at (972)613-127.

3. Dr. Vijaya Nama MD. PA will not base condition for treatment or payment for healthcare services on your completing and signing this authorization.

   Initials: _____

   For additional information regarding disclosures of uses of my health information, I acknowledge I may obtain a copy of Dr. Vijaya Nama MD. PA Notice of Privacy Practice at any time from the receptionist or by contacting the above business office.

Section B: Consent:

In the event that a family member or caregiver attends my office visit and is in the exam room at the time of the evaluation and/or treatment, I give Dr. Vijaya Nama MD. PA and its physicians, physician assistants, nurse practitioners or employees my permission to discuss freely my condition, treatment, diagnosis, or insurance/payment issues with that person.

Initials: _____

May we leave a message on your home phone? Yes/No If so, what is the number? _____

May we leave a message on your cell phone? Yes/No If so, what is the number? _____

May we leave a message on your work phone? Yes/No If so, what is the number? _____

We address our patients by name in our office and reception area. If you do not wish for us to do this, please note here. _____

With whom may we discuss or release information about your care, treatments, or diagnosis?

_____ Relationship to patient: _____

_____ Relationship to patient: _____

Printed Name_____ Signature: _____ Date: _____

VIJAYA NAMA MD PA

Consent for Treatment by Nurse Practitioners and Physician Assistants

Nurse practitioners (NP) and Physician assistants (PA) are healthcare professionals licensed to practice medicine with physician supervision. NPs and PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care and assist in surgery. NPs and PAs are trained in intensive education programs accredited for the nurse practitioner or physician assistant. Upon graduation they are required to take a national certification exam to receive their state licensure.

I understand that the nurse practitioner/physician assistant and the physician work together as a team to provide my medical care.

This agreement will remain in effect until otherwise stated by me.

Patient/Parent/Guardian Signature:_____

Printed Name:_____ Date:_____

Witness signature:_____

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CONSENT FOR AUTHORIZATION FOR USE /RELEASE OF HEALTH INFORMATION

This authorization form applies only to the release and disclosure of protected health information (PHI).

I authorize the following information to be sent to the address above.

_____ Copies of all medical records.
_____ History and Physical Examination Lab Reports and Physician Reports
_____ Other_____

_____

I understand that this information may include any history of acquired immunodeficiency (AIDS), (STD) sexually transmitted diseases, (HIV) human immunodeficiency virus infection. Behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Name of person or health facility to which we are requesting medical records

Physician Name or Hospital Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax _____

_____

Print Patient's Name _____ Patient's Signature

_____

Date of Birth _____ Date