CENTRAL PRIMARY CARE
INTERNAL MEDICINE
Taking Care of Families

NEW PATIENT REGISTRATION

PLEASE PRINT

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (___)_____ CELL PHONE: ( ) ___ _____

BIRTHDATE:_____ AGE:____ GENDER: ___ Social S. # XXX-XX-_____

REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: (___)_____

RELATION TO PATIENT: _____ MARITAL STATUS: _____

EMPLOYER NAME: _____ PHONE: (___)_____

PRIMARY INSURANCE: _____

ADDITIONAL INSURANCE INFORMATION:

It is customary to pay for services when rendered unless other arrangements have been made with our office.

Authorization to release information: I hereby authorize release of any medical information necessary in the course of treatment. I also hereby authorize any payment for medical services provided to be made directly to the physician.

Date: _____ Patient's signature: _____

Central Primary Care

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I, _____ , hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy makes available detailed information about how the practice may use and disclose my Privacy Health Information (PHI).

I understand that the physician has reserved the right to amend his or her privacy practices that are described in the notice. I also understand that a copy of any amended notice will be available to me at my request.

Signature:_____

Date:_____

Central Primary Care

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, hereby request **Central Primary Care physician(s),** to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following request:

PHONE:
You can contact me by phone at _____

Leave messages on answering machine_____YES _____ NO

Leave messages with any other person _____ YES _____NO
(THIS INCLUDES LABS, TEST, X-RAY RESULTS)

IF YES, NAME THE PERSON(S) AUTHORIZED TO RECEIVE MESSAGE:

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

EMAIL ADDRESS: _____

_____
SIGNATURE DATE

If you are not the patient, please specify your relationship to the patient: _____

_____

Patients Name DOB

LABS AND DIAGNOSTIC RESULTS NOTIFICATION FORM

FOR LAB/XRAY/MRI/ RESULTS THE FOLLOWING ARE AVAILABLE:

*Web Portal Notification for **Normal Results only** _____YES _____NO

You need to be web enable with office- ask receptionist to web enable you.

Please provide your email: _____

Example of the message you will receive:
"Your labs are Normal, Sincerely, Central Primary Care"

*Text Notification from Web Portal for **Normal Results only**
_____YES _____NO

Example of the text message you will receive:
"Your labs are Normal, Sincerely, Central Primary Care"

Please provide your cell number: (_____) _____-_____

*ABNORMAL LABS AND ABNORMAL TEST RESULTS WILL STILL RECEIVE CALL WITHIN 2-3 BUSINESS DAY

_____

PATIENT SIGNATURE DATE

If you are not the patient, please specify your relationship to the patient: _____

☐ PT HAS REFUSED TO SIGN FORM

EMAIL POLICY

It is the policy of Central Primary Care that Email communication should be concise and used for the following purposes only:

- Appointment scheduling
- Refills
- Referrals

The Email Communication between office staff and Providers at Central Primary Care are **NOT TO BE USED FOR THE FOLLOWING:**

- Emergency Situations
- Questions regarding your health

After Hours, we have a 24 hour answering services for any emergencies you might have.

For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the email relationship.

Never share professional email accounts with family members. Any emails not coming from the patient itself will not be addressed, as it might violate HIPPA privacy regulations.

Email responses will be returned by the end of the business day. If there are any emergencies you are responsible to call the office during business hours and or go to the nearest emergency room and or you can also call the answering services after business hours.

DO NOT EMAIL PROVIDERS FOR EMERGENCY SITUATIONS.

Please be aware that other providers in our practice have access to your email.

Emails received not during business hours will be returned by the end of the next business day

You may use our secure message portal through our electronic medical records.

_____

Patient Name DOB

_____

Patients Signature Date

Central Primary Care

PATIENT ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY

All professional services are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with the office manager. Necessary forms will be completed to help expedite insurance carrier payments. However, you are responsible for all fees, regardless of insurance coverage.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Haresh Sawlani for medical services rendered to my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Haresh Sawlani to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment and to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Haresh Sawlani and I understand that by making this request, I become fully financially responsible of any and all charges incurred in the course of treatment authorized. I further understand that the fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Patients Name DOB

_____

PATIENT SIGNITURE DATE

Central Primary Care

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. PLEASE READ CAREFULLY, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payment and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some and perhaps all of the services you receive may be non-covered, not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your state ID/driver's license and a current up-to-date insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find an alternative medical care. During that 30 day period, our physicians will be able to see you on emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines.

_____

Signature of patient or responsible party Date

Patients Name: _____DOB:_____