SAPNA BRAHMBHATT, M.D.

FINANCIAL POLICY

The medical services provided by our office are services you have elected to receive. This implies responsibility on your part.

Copays: Copayment is due at the time of service**,** as required by law. Copayment may be made with **CASH** or **CHECK ONLY**. The physician does not accept credit cards.

Self Pay: Payment is due in full at the time of service if you do not have insurance, if our office does not participate with your insurance plan, or our services are not covered under your insurance plan. Self pay patients must pay CASH or by MONEY ORDER ONLY. We do not accept personal checks or credit cards for self-pay payment.

Medicare: Dr. Brahmbhatt is a Medicare participating provider. Medicare, as well as, your secondary insurance will be billed for you. You are responsible for all copayment, coinsurance or deductible amounts stated by Medicare and your secondary insurance company.

Secondary Insurance: Your medical claim will be forwarded to your secondary insurance after payment has been received from your primary insurance.

HMP/PPO/Major Medical: Dr. Brahmbhatt participates with many insurance plans, though it is your responsibility for confirming that the physician participates in your insurance plan. You are required to pay your copayment stated on your identification card at the time of service. Any additional amounts due will be billed to you once your insurance company has processed your claim.

Referrals/Authorization: You are responsible for obtaining a referral/authorization for services provided, if required by your insurance company, from your primary care physician. You may be financially responsible for any charges denied due to absence of a referral/authorization. Your scheduled visit may also be rescheduled due to absence of a referral/authorization.

Patient Billing: A statement of your financial responsibility will be sent to you after your claim has been processed by all of your insurance carriers. Failure to pay your patient responsibility may result in your account being assigned to collections. Please contact our billing department if you have any questions regarding your bill. A fee of $20.00 will be added to your account for any returned checks.

Interest: An interest charge of 1.5% per month will be added to all unpaid balance.

Collections: All accounts past due for over 90 days will be sent to collections. A $50.00 service fee or 10% of the account balance (whichever is greater) will be added to the unpaid balanced prior to being sent to collections.

I have read the above policies regarding my financial responsibility to Dr. Brahmbhatt for providing medical services to me or my dependents (s). I agree to pay Dr. Brahmbhatt any amount due after insurance payment has been made by my insurances and any contractual adjustments have been made. I understand that if I do not have health insurance **OR** if I provide incorrect health insurance information, I am personally responsible for the full amount of my bill. Furthermore, I understand that if the services provided by Dr. Brahmbhatt are not covered under my insurance plan, for any reason, I am responsible for payment of all charges.

I understand that is my responsibility to inform Dr. Brahmbhatt's office if there is a change in my health insurance.

Patient Name _____

Responsibility Party_____ Relationship to Patient _____

Signature of Patient/Responsible Party _____Date _____

Dr. Sapna Brahmbhatt
Otolaryngology/Otology

Today's Date _____

Name_____ Medication allergies _____

Height_____ Weight _____

Past Medical History

_____

_____

Past Surgical History

_____

_____

_____

Medications_____

_____

_____

Alcohol use yes_____ amount_____ Tobacco use yes___ amount_____

no _____ former___ never___

Other Social History (i.e. living arrangement, drug use)

_____

_____

Family History (i.e. cancer, diabetes, heart disease)

_____

_____

Review of Systems:

Constitutional (i.e. fever, weight loss, fatigue)_____

Eyes_____

Ears, Nose, Mouth, Throat _____

_____

Heart/circulation _____

Lungs/breathing _____

Gastrointestinal (i.e. stomach, diarrhea, ulcer) _____

_____

Genitourinary (i.e. kidney, bladder, reproductive organs) _____

_____

Musculoskeletal _____

Skin and/or Breast_____

Neurological _____

Psychiatric_____

Endocrine (i.e. thyroid, diabetes) _____

Blood/Lymph Nodes_____

Allergies/Immune system _____

Sapna Brahmbhatt, M.D.
Otolaryngology/Otology

Date:_____

Name_____M/F Date of Birth: _____
Address _____City _____ State_____ Zip _____
Home Telephone: _____Cellphone:_____ Work Phone:_____
Social Security Number:_____Marital Status S M D W Student: FT PT
E-mail address: _____

MEDICAL INSURANCE
Insurance Co. _____
Policy # _____
Policyholder's Name_____
Social Security # _____
Date of Birth _____ Sex _____
Relationship to Patient _____

SECONDARY INSURANCE
Insurance Co._____
Policy # _____
Policyholder's Name _____
Social Security # _____
Date of Birth _____ Sex _____
Relationship to patient_____

PRIMARY PHYSICIAN
Name_____
Address _____
Phone # _____ Fax # _____

PERSON RESPONSIBLE FOR PAYMENT
Name_____
Address _____
Home Telephone_____ Cellphone/Alternate Phone _____
Relationship to patient _____

EMERGENCY CONTACT INFORMATION
Name_____
Address _____
Home Telephone_____Work phone_____ Cellphone_____

AUTHORIZATION AND CONSENT FOR TREATMENT
I hereby authorize Dr. Sapna Brahmbhatt to examine, evaluate and treat the above named patient. I further state that I am over 18 years of age and authorized to give such consent for treatment (as the patient or guardian/parent/health proxy of the above-mentioned patient) **OR** am an emancipated minor. I acknowledge that the information that I have the provided is true and correct. I hereby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I also acknowledge that I am fully responsible for payment of services regardless of my health insurance coverage. I certify that all health insurance information that I have provided is **TRUE** and **CORRECT.**

_____

Signature Relationship Date

Dr. Sapna Brahmbhatt
Otolaryngology/Otology

Acknowledgement of Receipt of Privacy Notice

Our practice is dedicated to maintaining the privacy of your confidential, protected health information (PHI). In accordance, our office creates records regarding your health status and the health care/services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which this practice may use or disclose health information about you. It also describes your rights and our obligations regarding the use and disclosure of that information.

By signing below you acknowledge that you have received our Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Date

_____ _____

Print Name if signature is on behalf of patient Relationship

4/13/2003

Dr. Sapna Brahmbhatt
Otolaryngology/Otology

RELEASE OF MEDICAL INFORMATION REQUEST

Patient medical records are CONFIDENTIAL. Protecting your privacy is very important to us. Therefore, according to new federal regulations, we may not discuss or release information to anyone but the patient unless you authorize us to do so. We want to make sure that you receive information that is necessary to assist us in providing quality care and service. Please complete the information below so that we may better serve you and your needs.

Patient name:_____ Date of Birth:_____

SS#:_____

I give this office permission to contact me by (initial all that apply):

_____ Telephone my home

_____ Telephone my work Phone#: _____

_____ Leave messages on answering machine

_____ Other, explain: _____

If you would like us to discuss your information with anyone other that yourself, please write his/her name below and relationship (i.e. spouse, children, friend, etc.):

_____

_____

_____

_____

_____

_____

Signature of Patient of Personal Representative: _____

Print Name if not patient: _____ Relationship: _____

Date: _____

4/14/03