Neeta R. Bhardwaj, M.D., P.A.

Patient Information Sheet

Date: _____

Patient's Name: _____
Last Name First Name Middle Name

Sex: □ Male □ Female Age: _____ Date of Birth: _____

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code:_____

Primary Language(s):_____

Child primarily resides with (check one): □ Both parents □ Mother □ Father □ Other: _____

Race:

□ White □ Black □ Native American

□ Asian □ Other □ Unknown

Ethnicity:

□ Hispanic □ Non-Hispanic

Name of person who has financial responsibility for this patient: _____

Mother's Information

Mother's Name: _____
Last Name First Name Middle Name

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced Date of Birth: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ □ Primary E-mail?

Mother's Social Security Number: _____ Driver's License Number: _____State:_____

Employer: _____ Occupation:_____

Address (if different from patient's address):

Street Address: _____ Apt #:_____

City:_____ State:_____ Zip Code:_____

Continued on back →

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

Father's Information

Father's Name: _____
Last Name First Name Middle Name

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced Date of Birth: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ □ Primary E-mail?

Father's Social Security Number: _____ Driver's License Number: _____State:_____

Employer: _____ Occupation: _____

Address (if different from patient's address):

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code:_____

Emergency Contact Information

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance Name: _____ Policy Number: _____

Name of Insured: _____ Date of Birth: _____

Secondary Insurance Name: _____ Policy Number: _____

Name of Insured: _____ Date of Birth: _____

I attest that the above information is correct to the best of my knowledge.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date: _____

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

_____ _____

Name of Patient Patient's Date of Birth

General Consent for Treatment

I am here voluntarily for medical care and consent to treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants, and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or course of treatment.

Electronic Health Record/Health Information Exchange

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider, who also participates in an electronic health record system, they may have access to your medical record. If you do not want medical records shared with other providers, please notify the office manager or the physician.

Authorization to View Prescription History from External Sources

I authorize Dr. Neeta R. Bhardwaj, M.D., P.A., to view any and all available prescription information from an external source. I am aware that Dr. Neeta R. Bhardwaj, M.D., P.A. uses a secure connection to SureScripts to send and receive most prescriptions in the office.

Acknowledgements

I acknowledge that administrative data, demographic information, and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental, and non-governmental reporting, and comparisons with other providers. In some instances, performance data is aggregated.

I have read all the above sections and agree to them all by signing below.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date:_____

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

Financial Policy

_____ _____

Name of Patient Patient's Date of Birth

We at Dr. Neeta R. Bhardwaj M.D., P.A. are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask us if you have any questions about this financial policy.

Please be aware not every service recommended by your provider is covered by your insurance. It is your responsibility to know what is or is not covered, policy limitations, referral and authorization requirements. By signing this financial policy, you understand and agree to be responsible to pay for any services that are not paid by your insurance company. Dr. Neeta R. Bhardwaj, M.D., P.A. will not enter into disputes with your insurance company, but we can assist you with any difficulties.

Any laboratory test, injections or procedures done in the office are not included in the office visit and WILL result in an additional charge to you or your insurance company.

You are personally responsible for payment of all charges that result from care provided by Dr. Neeta R. Bhardwaj, M.D., P.A. including any amounts not covered by your health plan. To assist us in establishing your office visit financial amount, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and Dr. Neeta R. Bhardwaj, M.D., P.A. with any additional information requested to complete the processing of claims filed on your behalf, such as Dr. Neeta R. Bhardwaj listed as your Primary Care Provider (PCP).

If we are not contracted with your health plan, we may require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement for your health plan. Should your health plan require a more detailed description of services, please have them request it in writing.

Regarding divorce/single parents:

Dr. Neeta R. Bhardwaj, M.D., P.A. does not get involved in disputes between divorced/single parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse/parent of child.

Assignment of benefits:

In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to Dr. Neeta R. Bhardwaj, M.D., P.A. for services provided to you.

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payments directly to Dr. Neeta R. Bhardwaj, M.D., P.A. for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I fully understand that I am ultimately responsible for any amount not covered or denied by my insurance.

Release of information:

I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process current and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time for an indefinite period or until I submit a written revocation of this release at any time, except with regard to disclosures already made.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient:_____

Date:_____

Continued on back →

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

Office Financial Policies

OFFICE VISITS: All applicable fees must be paid at the time of service, including, but not limited to, co-pays, deductibles, procedures and/or immunizations if not covered by your insurance plan. Dr. Neeta R. Bhardwaj, M.D., P.A. accepts cash, checks, MasterCard, Visa, Discover, and American Express as forms of payment.

Initials: _____

MEDICAID: Medicaid patients need to have a current and active policy at the time of check-in. If coverage is not active, the appointment will either be rescheduled or the guardian accompanying the patient will be considered personally responsible for all fees associated with the office visit at the time of service.

Initials: _____

LATE APPOINTMENTS: Patients arriving more than fifteen minutes late will be rescheduled.

Initials: _____

MISSED APPOINTMENTS: When a patient "no-shows", other patients who are sick are denied that time slot. As a courtesy, we ask that you please give a 24 hour notice to reschedule or cancel your appointment. If you no-show on a Saturday, you will no longer be able to schedule appointments on a Saturday. Patients who repeatedly miss appointments may be dismissed from our practice.

Initials: _____

COLLECTIONS: Should collections become necessary I agree to pay all collection agency fees.

Initials: _____

INSURANCE: As a courtesy to our patients, we bill the primary insurance for office visits. In order for us to provide this service, we need documentation of insurance. This includes a copy of the insurance card, yearly deductible amount, maximum yearly allowable for preventative care, any co-pay requirement, and coverage effective dates. If we bill insurance, the patient remains responsible for 1) the deductible amount, 2) any co-payments, 3) any unpaid balance after 90 days, 4) the portion of our charges not covered by insurance (unless collection of the uncovered portion is prevented by contract, such as a preferred provider agreement).

For all new patients, we will continue to request payment at the time of service, until we have all insurance information and payment/reimbursement on file.

Initials: _____

RETURNED CHECKS: Our NSF (non-sufficient funds) fee for returned checks is $35.00. If your check is returned for insufficient funds, then we will no longer accept personal checks as a deposit on your balance due. You can pay by credit card, cash, or a cashier's check.

Initials: _____

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date: _____

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

HIPAA Information and Consent Form

_____ _____

Name of Patient Patient's Date of Birth

The Health Information Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been part of our practice for years. The form is a "friendly" version. A more complete text is available in the office up on request.

What this is all about: Specifically, there are rules and restrictions on who may view or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goals of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as it is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination, room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments; we may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of any changes to the office policy and new electronic chart information that you might find valuable or informative.
3. This practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the physician.
6. Your confidential information will NOT be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws. You may request your child's records and they will be provided to you for a nominal charge. If you are transferring to a new physician, we will send your records to the new MD office at no cost AFTER receiving a signed medical record release in our office or from the new physician.
8. We may change, add, delete, or modify, any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are NOT obligated to alter internal policies to conform to your request.

We maintain physical, electronic, and procedural safeguards to protect information we collect about the patient.

I, the parent/guardian/patient of the person listed above do hereby consent and acknowledge my agreement to the terms set forth in the **HIPAA Information and Consent Form** and any subsequent changes in office policy. I understand that this consent shall remain in effect from this time forward.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date: _____

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097

Neeta R. Bhardwaj, M.D., P.A.

Authorization for Medical Treatment/Delegation of Consent

_____ _____

Name of Patient Patient's Date of Birth

I hereby authorize full medical delegation to the following individual(s) when I am unavailable to give consent:

1. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

2. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

3. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

4. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

The above listed individual(s) are able to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, immunizations, and elective as well emergency care. This delegation shall be valid until I withdraw delegation of consent.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date:_____

11710 FM 1960 West, Houston, TX 77065
www.neetabhardwajmd.com
(281) 469-6097