Today's date: ______________ *Past due amount:* ____________ *Paid:* ____________

Name: ____ DOB: ______________

Reason for visit: ***please note that excessive requests will require a new visit (this is the #1 reason for excessive wait times, so please think of other).***

____**new or worsening old problem:** ____

what is it & where: ____
When did it start: ____
Related symptoms: ____
severity (1-10/10): ____
what helps or makes worse ____

____***work in issue (1 problem only)***: ____________________________________
____***shot(s) only, re***: ____
____***quick script issue, re***: ______________________________(has to be pre arranged)
____**meds and/or results review:** ____bloodwork ____radiology____other:___________
____**Procedure only, re:** ____
____**physical only** ***(problem lists will be pushed to a follow up visit)***
____**new patient/establish care:** ____
____**blood draw w/visit today,** + any labs by request: ____________________________

Please update so that we know it is accurate in your e-chart (at least every 6mo If nothing has changed since your last visit please just indicate with N/A):

Phone/Email//Address (each):

Pharmacy of choice (also mail order):

Drug Allergies:

Surgeries:

Family history (parent & siblings):

(Circle) Tobacco drug alcohol: ____Current ____Never ____Former

Medication list:

Authorization for Disclosure of Health Information

I hereby authorize (facility or MD name) ______________________________ to release medical information from the records of :

Patient name ______________________________ DOB ___/___/____ SS # ____-____-____

Pt address ______________________________ City ____________ State___ Zip _____

Dates of treatment should include ______________________

Information to be disclosed:

__ Discharge summary/ instructions
__ ECG/EKG(s)
__ Medication record
___Last three office notes
___xray reports
___H&P and allergies
___Entire chart
____ last two lab reports

Purpose or need for the disclosure is continued medical care. This information is to be disclosed to:

Vijay Patel Family Medicine
1520 Glenwood Ave
Raleigh, NC 27608
P 919.782.5288
F 919.782.5287

My refusal to sign this form will not adversely affect my ability to receive healthcare services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I have the right to revoke this authorization by written notice to the healthcare provider listed above.

This authorization expires 90 days from the date signed below.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), (ARC) and or human immunodeficiency virus (HIV).

Fees: I understand and free that there may be costs associated with this request in compliance with State Copying laws.

______________________________ signature ___/_____/_____ date

Patient E-Mail Consent Form

(For the purpose of General Correspondence and Testing Results, etc...)

Patient Name: ______________________ Patient MR # ______________

Patient Email: ______________________

Provider Email: apptdrpatel@live.com

Patient Representative/Guardian:

Name: ______________________ Relationship: ______________

INSTRUCTIONS

To communicate by E-mail, the Patient shall:

1. Avoid use of his/her employer's computer.
2. Inform the Provider Office of changes in the Patient's E-mail address.
3. Take precautions to preserve the confidentiality of E-mail.
4. Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive within a reasonable period of time.

CONDITIONS FOR THE USE OF E-MAIL

The Provider Office cannot guarantee but will use reasonable mean to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider Office must consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. The Provider's Office cannot guarantee that any particular E-mail will be read or responded to.
2. E-mail must be concise. The Patient should schedule an appointment if the issue is to complex or sensitive to discuss via E-mail.
3. E-mail communications between Patient and Provider's Office will be filed in the Patient's permanent medical record.
4. The Provider Office will not forward patient-identifiable E-mails without the Patient's prior written consent, except as authorized or required by law.
5. It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.

RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

1. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. E-mail senders can easily misaddress and E-mail.
3. Employers and on-line services have a right to inspect E-mail transmitted through their systems.
4. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider's Office staff and myself. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated E-mail address specified above. Any questions I may have were answered.

______________________________ ______________

Patient or Representative/Guardian Signature Date

______________________________ ______________

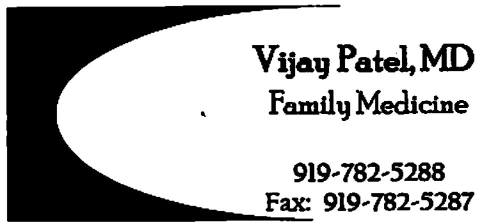
Provider Office Staff Signature Date

____The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of whose name is listed as the insurance policy holder. For unaccompanied minors, non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment.

____ Processing copies or transfers of medical records is subject to a $25 administrative fee and a higher fee may be charged if there are over 75 pages of records.

____Acknowledgement - Notice of Privacy Practices
I authorize Dr. Patel's staff to communicate with me by phone, answering machine, letter, or email at home or business regarding appointments, care, or billing.

Patient Name ____ Date___/___/____
Staff's initials___________________



1520 Glenwood Ave Raleigh NC 27608

Email: apptdrpatel@live.com
Website: vijaypatelmd.com

We will inquire about your insurance and ask to see your insurance cards at every visit. Please note that we cannot file insurance for your services unless we have a card that is correct and current. Although this is often regarded as an inconvenience to you, we have found that it is now a necessity due to frequent changes in carriers and necessary information.

It is the policy of this office to follow up on missed and/or cancelled appointments and send bills for appointments that were missed. This is not meant to be harassing, but rather to make sure you receive the appropriate care for your specific condition. In the event that repeated attempts are not followed up with an appointment, further action may include termination from the practice.

Financial Assignment and Agreements - Initial next to each statement and sign and date at the bottom.

____ I request payment of authorized insurance benefits be made on my behalf to my physician for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits of the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

____I understand that I am financially responsible for all charges not covered by insurance. Copays, coinsurance amounts, deductibles are payable at the time services are rendered. If payment is not made at the time of service, a billing fee $25 will be added.

____I understand that I will be charged $25 for a missed appointment unless I give a 24 hour notice to either cancel or reschedule the appointment. I understand there is a $50.00 charge for missed annual physical appointments.

____I understand there is a $25 service charge for returned checks.

____I understand that if my insurance company requires and authorization, it is my responsibility to make sure one is in place prior to my visit. If no authorization is in place, I accept full financial responsibility.

____I understand that if my account balance becomes past due and is sent to an outside collection agency, I will be responsible for any additional fees incurred.

Vijay Patel Family Medicine
1520 GLENWOOD AVE, RALEIGH NC 27608

Phone: 919-782-5288 fax 919-782-5287
apptdrpatel@live.com

Today's Date:

PATIENT INFORMATION

Last name:	First:	Middle:	Marital Status S M D Other______________
Is this your legal name? ◌ Yes ◌ No	If not, what is your legal name?	Former name:	Birth date: / Age: / Sex: ◌ M ◌ F

Full Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist at each visit.)

Person responsible for bill:	Address (if different):		Phone:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate carrier of primary insurance: (BCBS, etc)

Subscriber's name:	Subscriber's S.S.	Birth date:	Group no.:	Subscriber no.:	Co-pay: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Subscriber ID

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vijay Patel Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature Date