



ASHVIN J.PATEL M.D., P.A.
102 PAUL MELLON COURT #102
WALDORF, MD 20602
301-645-7414

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. Ashvin J. Patel's office will ONLY disclose your personal health information in ways listed below. If a person(s) is not listed we will NOT disclose any of your medical information to them.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES form to help you better understand our policies about your personal health information.

I wish to be contacted in the following manner (check all that apply):

❖ **HOME TELEPHONE**

O.K. to leave message on recorder with detailed information.

O.K to leave information with spouse.

Other (Please list names)

Leave message with call back number only.

❖ **WORK TELEPHONE**

O.K. to leave message with detailed information.

Leave message with call back number only.

Patient Name (Please print): _____

Signature: _____

Date: _____

PATIENT REGISTRATION FORM

Patient Name: _____ DOB: ____ / ____ / ____ SEX: _____

Social Security # _____ - _____ - _____

Home Number: _____ Cellphone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employment Information: _____ Position: _____

Employer: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Name Insured: _____

Policy/Group # _____ ID# _____

Secondary Insurance: _____ Name Insured: _____

Policy/Group # _____ ID# _____

Emergency Contact Person:

Name: _____ Relation: _____

Phone Number: _____

Address: _____

Reason for Visit: _____ Allergies: _____

Whom can we thank for referring you? _____

I authorize you the release of any medical information necessary to process all insurance claims. I permit a copy of this authorization to be used in place of the original. I here authorize that payment made directly to Dr. Patel. *I understand that if my insurance company does not pay for the service, I am responsible for all bills.*

Print Name: _____ Signature: _____ Date: _____

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OFFICE POLICY & PROCEDURE

Thank you for selecting us as your primary care doctor. To promote a long term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. PLEASE, read this agreement carefully and ask any questions or bring up any concerns you may have BEFORE treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO THE TERMS OF THIS AGREEMENT.

- **TREATMENT:**

You will find our entire staff is dedicated to helping you improve your health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with Dr. Patel at any time. I consent to having my picture taken for the purpose of patient's accurate record keeping only.

- **PRESCRIPTIONS:**

If you are on any maintenance medication and have been more than three months since your last office visit, your medication can be denied and you will be asked to schedule an appointment first. We do not refill medication through fax, be sure to have your prescriptions refilled during your office visit.

- **INSURANCE:**

If this office is able to accept your insurance, the patient is FULLY RESPONSIBLE for the charges for any treatment that we rendered. Your insurance MAY NOT COVER the services or may only PARTIALLY cover them. It is patient's responsibility to know the coverage of their insurance policy. All deductibles, co-payments; co-insurances are collected prior to your visit with Dr. Patel.

- **MISSED APPOINTMENTS:**

When we schedule your appointment, your time is reserved exclusively for you. When you fail to notify us that you are unable to keep a scheduled appointment, another patient in need of treatment is unable to receive one. Therefore, we request that you give us at least 24 hour notice when you realize that you are unable to keep an appointment. When the requested notice is not given, a fee of \$35.00 per missed scheduled appointment will be charged.

*Appointment cards are given as a reminder. Reminder calls are a **courtesy** and cannot be guaranteed each time.*

SERVICE CHARGES:

- **MONTHLY BILLING:**

Even though an insurance claim has been filed, you will receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. A \$10.00 charge will be applied every month to accounts with balances outstanding 60 days or older, regardless of outstanding insurance.

- **RETURNED CHECKS:**

There is a \$25.00 fee for bounced checks. The payment for the bounced check must be paid in Cash at the office or over the phone using Visa /Discover/ MasterCard to cover the check amount and the fee. Once the check is bounced, no check payment will be accepted in the future.

PATIENT NAME: _____ SIGN: _____ DATE: _____