ARUNA GUPTA MD., INC
6850 BROCKTON AVE STE 108
RIVERSIDE, CA 92506

PATIENT INFORMATION:

Last Name:________________________M.I.________First Name:__________________

Date of Birth:______Social Security #:______________Driver Lic_________Age__

Address:____________________City___________________State_______Zip_________

Home Phone: (   )   -   Cell phone: (   )   -

Email Address:____

Marital Status (please circle)   M   S   W   D   Student: F/T   P/T

Occupation:__________________ Employer:_________________________

Employer Address:_________________City:_______________State:_________Zip:_________

Work Phone: (   )   -   Language Preference:_____________________

INSURANCE INFORMATION:

Insurance Name:___________________PPO_______Medi-Cal_________HMO_______

ID #______________________________Group/Policy #__________________________

Policy Holder Name:__________________________________Relationship:____________

Policy Holder Date of Birth:____________Policy Holder SSN________________________

Employer:____________________Employer Address:______________________________

City:________________________State:______Zip:______________

EMERGENCY CONTACT INFORMATION:

Emergency Phone #:_________________Name & Relationship:______________________

AUTHORIZATION TO PAY PHYSICIAN

I authorize release of my information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable to me directly to Aruna Gupta MD. I also agree that I will be responsible for payment of charges regardless of payment or denial of payment from my insurance company, including charges deemed not covered.

Today's date:_______________________Patient's Signature:________________________

Financial Policy

Welcome to Aruna Gupta M.D. APC. We look forward to providing you with the highest quality care and trust. We hope that you will find our staff friendly and helpful. Our office participates with many major insurance companies. Due to the complexities of individual plans, it is impossible for us to know about your specific benefits.

- Please have your current insurance ID available at each visit so we can avoid filing errors. Errors and changes in policy coverage prevent us from filing appropriately with your insurance company. We will NOT file an insurance claim for you if we do not have a current copy of your ID card. If at any time your insurance should change, especially during pregnancy, our office must be notified immediately to accurately file claims.
- The cost of medical care is determined by the nature and complexity of your illness or the contract between you and your insurance company. As a service to you, our office makes every reasonable effort to obtain payment according to ultimately responsible for paying your medical bills. If your insurance company rejects the claim or delays the payment, the office will bill you after 60 days of those charges. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.
- All co-payments, co-insurance and deductible amounts are due and payable at the time you check in. This policy is in accordance with the legal requirements for collection patient responsibility amounts. All charges are due and payable 60 days from date of service. Unresolved balances maybe placed with an outside collection agency and maybe subject to attorney fees and collection agency fees.
- The responsibility for payment for services rendered to any dependent children whose parents are divorced or separated will be with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without inclusion of our office
- Failure to provide necessary referrals and/or authorizations will result in all charges for services becoming the sole responsibility of the patient/responsible party.
- Self paying patients will be expected to pay in full at the time of service.
- A $20.00 service fee will be applied to your account for any and all returned checks.
- Our practice accepts checks over $10.00 and cash. We do not accept credit cards at this time. We will try to deliver the finest care at the most reasonable cost to our patients, therefore, payment is due at the time the service is rendered unless prior arrangements have been made. In most cases your insurance plan requires you to make a co-payment at each visit. We will ask you for your co-payment when you check in. if you are unable to pay your co-payment we may ask that you reschedule your appointment.

ACKNOWLEDGMENT OF OFFICE/FINANCIAL POLICIES

I have read and understand the financial policy for Aruna Gupta, M.D., APC. I understand that it is my responsibility to pay any co-pay or deductible according to my insurance policy. I understand that if I am a self paying patient, I must pay for all services on the day they are rendered. I understand that any remaining balance due after my insurance company sends payment will be paid no later than 60 days from the date of service.

I understand that Aruna Gupta, M.D., APC may send my account to an outside collection agency for unpaid balances. I may incur attorney fees and collection fees.

I understand that I must have a valid ID and insurance card at each visit and if anything changes, I will notify the office immediately.

Signed:____Date:________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Aruna Gupta, M.D., APC to release any and all parts of my records to any person or corporation which may be liable for all parts of the charges for services, including but not limited to insurance companies, employers and/or medical doctors.

Signed:___________________________________Date:_____________________

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

We are required by applicable federal and state law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to maintain the privacy of your medical information. We are also required to give notice about our private practices, our legal duties and your rights concerning your medical information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such charges are permitted by applicable law, for all medical information that we maintain, including medical information created or received before we made any changes.

We may use and disclose medical information about you for the following purposes:

Treatment - We may use your medical information to treat or disclose your medical information to a physician or other health care provider providing treatment to you

Payment - We may use and disclose your medical information to obtain payment for service we provide you.

Healthcare Operations -We may use and disclose your medical information in connection with normal course of operating our practice. These may include quality assessment activities, performance evaluations, conducting training programs, accreditation and certification, licensing or credentialing activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses or disclosures of your medical information will only be made with your written authorization or in response to legal requirements such as disaster relief, court orders, suspected abuse, neglect or domestic violence, or in certain instances affecting national security.

You have the following rights with respect to your protected health information which you may exercise by written request:

(1) You have the right to request additional restrictions on the use or disclosure of your medical information. We are not required to agree to these additional restrictions, bit if we do, we will abide by our agreement which must be in writing.
(2) You have the right to inspect and copy your protected health information. Charges may apply.
(3) You have the right to request amendments to your protected health information.
(4) You have the right to receive an accounting of disclosures of your personal health information for other than treatment, payment, health care operations or pursuant to other authorized disclosures as stated above.
(5) You have a right to obtain a copy of this notice.

If you are concerned that we have violated your privacy rights or you disagree with a decision we have made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services (DHHS). We will provide you with the address to file your complaint upon request.

Contact office: Aruna Gupta M.D., APC 6850 Brockton Ave Ste 108, Riverside, CA 92506
Ph (951) 787-7753 FAX (951) 787-7763

Aruna Gupta M.D., APC

Notice of Privacy Practices Written Acknowledgment Form

I, ____, have received and read a copy of

Aruna Gupta M.D., APC's Notice of Privacy Practices.

Signature:____Date:__________________

Aruna Gupta M.D., APC

6850 Brockton Ave Ste 108

Riverside, CA 92506

Phone (951) 787-7753

Fax (951) 787-7763

CONSENT FOR GENERAL PROCEDURES

I ____ give my consent to Dr. Aruna Gupta for any of the following procedures to be done when needed in the office:

- Pap Smear
- Urinalysis
- Vaginal Cultures
- Wet Mounts
- STD Cultures

Signature:_____________________________________Date:________________________