Patient Information

Name_____
Last First M.I.
Mailing Address_____
Street Apt# City State Zip
HomePhone_____WorkPhone_____CellPhone_____

Email_____Date of Birth____/____/____Age_____Sex_____Marital Status_____

Parent or Responsible Party

Name_____
Last First M.I.
Mailing Address_____
Street Apt# City State Zip
HomePhone_____WorkPhone_____Cell Phone_____

Email_____Date of Birth____/____/____Age_____Sex_____Martial Status_____

Referred By:_____Primary CarPhysician_____Phone_____

Patient Authorization and Financial Responsibility

Consent for Treatment

I hereby voluntarily consent to the rendering of medical treatment by the physician and medical staff of J. Brahmatewari M.D.P.A. This may include examination, diagnostic and/or any other such medical treatment including genitalia as described by senate bill 698 deemed necessary for the diagnosis and treatment of my medical condition

Authorization to Release Medical Information

I hereby Authorize the physician and staff of J. Brahmatewari M.D.P.A. to release any medical information acquired in the course of my examination and treatment necessary for the processing of this claim and/or for the purpose of any insurance payment. I further authorize the release of said information to my primary physician and/or referring physician if applicable.

Assignment of Insurance Benefits/Medicare Benefits

I hereby authorize my insurance company to make payments on my behalf of any and all individual group benefits directly to the provider, physicians and medical staff of J. Brahmatewari M.D.P.A. for medical services rendered to me. Where Medicare benefits are applicable, I request that Medicare and supplementary insurance companies make payment of authorized medical benefits directly to the physician and medical staff of J. Brahmatewari M.D.P.A. on my behalf.

Guaranty of Payment

I know that my insurance policy is a contract between me and my insurance company and I understand that I am financially responsible for payment to the physician and medical staff of J. Brahmatewari M.D.P.A. for any charges not covered or allowable by my insurance company and all applicable out of pocket expenses, including deductible, co-insurance, and co-payments. Payment is due at the time of service.
I further understand and agree that if this account is placed to collections, I will be responsible for paying the balance owed to J. Brahmatewari M.D.P.A. plus any attorney fees if applicable. If my account is assigned to a collection agency, J. Brahmatewari M.D.P.A.shall be entitled to any/all collection cost in addition to my balance. Collection cost are 50% of my balance due.

I, _____(Print Name) ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS APPEARING ON THIS FORM. I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

_____

Patient or Legal Guardian Date Witness

HIPAA PRIVACY POLICY CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name_____

Relationship to Patient_____

Signature_____**Date**_____

_____ (initials) I refuse to sign the hipaa privacy consent form.

NO SHOW CHARGE POLICY

PATIENTS WHO DO NOT CALL TO CANCEL AND RESCHEDULE THEIR APPOINTMENT WILL BE CHARGED A NO-SHOW FEE OF **$20.00.**

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE CALL OUR OFFICE NO LATER THAT 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT.

AESTHETIC PRODUCT POLICY

ALL AESTHETIC PRODUCTS ARE **NON-REFUNDABLE**. IF YOU DEVELOP AN ALLERGIC REACTION WITHIN 7 DAYS OF PURCHASE AND THE REACTION IS DIAGNOSED BY THE DOCTOR, YOU CAN RETURN THE PRODUCT AND RECEIVE CREDIT.

VIDEO RECORDING/AUDIO RECORDING/PHOTOGRAPH POLICY

VIDEO RECORDING, AUDIO RECORDING, AND PHOTOGRAPHS ARE STRICTLY PROHIBITED WITHIN THE OFFICE.

I have read and understood the above POLICIES. I also agree to be responsible for any No-show fee that is charged to me if I fail to cancel my appointment.

Signature_____

POLIZA DE CARGO POR NO PRESENTARSE A LA CITA MEDICA

LOS PACIENTES QUE NO LLAMEN PARA CANCELAR O CAMBIAR SU CITA SE LES VA COBRAR **$20.00** DE RECARGO.

SI USTED NECESITA CANCELAR 0 CAMBIAR SU CITA, POR FAVOR LLAME A NUESTRA OFICINA POR LO MENOS 24 HORAS ANTES DE SU CITA.

POLIZA DE PRODUCTOS ESTETICOS

LOS PRODUCTOS ESTETICOS **NO PUEDEN SER DEVUELTOS**. SI TIENE UNA REACCION ALERGICA DENTRO DE LOS 7 DIAS DE HABER COMPRADO UN PRODUCTO Y HA SIDO DIAGNOSTICADO POR UN DOCTOR, USTED PUEDE DEVOLVER EL PRODUCTO Y RECIBIR CREDITO

POLIZA DE GRABACIÓN DE VIDEO / GRABACIÓN DE AUDIO / FOTOGRAFÍA

LA GRABACIÓN DE VIDEO, LA GRABACIÓN DE AUDIO Y LAS FOTOGRAFÍAS ESTÁN ESTRICTAMENTE PROHIBIDAS EN LA OFICINA.

He leído y entendido las POLIZAS anteriores. También acepto ser responsable de cualquier tarifa de que se me cobre si no llamo a cancelar mi cita.

Firma_____

Just Brahmatewari M.D.
Cosmetic Surgery and Dermatology

Cosmedic CENTRE
The Art of Beauty

Email Updates

The physician and staff at J. Brahmatewari M.D.P.A. would like the opportunity to provide you with the latest information, news, promotions and messages that can benefit your treatment. In order to better serve you and contact you more efficiently, we ask that you provide us with you email address.

Please note that the use of your email is intended only for use by J. Brahmatewari M.D.P.A.

_____ _____

First Name / Last Name Date of Birth

_____

Email Address

Just Brahmatewari M.D.
Dermatology & Cosmetic Surgery

Authorization to Release Information

PATIENT NAME: _____

DATE OF BIRTH: _____

Under the requirements for H.I.P.P.A. we are not allowed to release your **PHI (Protected Health Information)** to anyone without the patient's consent. If you wish to have your **PHI** released to any individual, you must sign this form. Signing this form will give consent to release your **PHI** which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) to the individuals indicated below. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize J. Brahmatewari M.D.P.A. to release my **PHI** to the following individuals.

Name_____ Relationship_____Tel:_____

Name_____ Relationship_____Tel:_____

Name_____ Relationship_____Tel:_____

Name_____ Relationship_____Tel:_____

Signature of Patient/Guardian: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co._____(HMO/PPO/POS/OTHER)

ID# _____ Group# _____

Ins. Address_____

Ins Tel .#_____ Main Subscriber_____

DOB_____ Relationship to Subscriber_____

SECONDARY INSURANCE

Insurance Co._____(HMO/PPO/POS/OTHER)

ID# _____ Group# _____

Ins. Address_____

Ins Tel .#_____ Main Subscriber_____

DOB_____ Relationship to Subscriber_____

RECORD RELEASE AUTHORIZATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

I, _____hereby authorize J. Brahamatewari M.D.P.A, and its employees to release:

- Medical progress notes
- Biopsy report , operative report
- billing information
- entire record

provided or to be provided to me and which identifies my name, address, social security number, Member ID number) to:

___ Myself

___ Doctor of Facility: _____

Address: _____

Phone: _____Fax: _____

Via:

- Fax#: _____
- Email Address:_____
- Mail to: _____

Address:_____

Patient or Guardian's Signature_____Date_____

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Tel: 305-751-7771 Fax: 305-756-027

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Tel: 305-341-7551 Fax: 305-756-0270