Harshida J Chaudhari MD PA- I and My Doctors Clinic, 2225 Williams Trace Blvd, Ste 109, Sugar Land, TX 77478

Patient Registration Information

Please READ AND complete ALL sections below!

PATIENT'S PERSONAL INFORAMTION

Please present Photo ID card to receptionist.

Name: _____ (last name) _____ (first name) Date of Birth:_____

Social Security #: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Email:_____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I here by give lifetime authorization for payment of insurance benefits to be made directly to Harshida J Chaudhari MD, PA- I and My Doctors Clinic, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ **Signature:**_____

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Harshida J Chaudhari MD PA- I and My Doctors Clinic, "The Clinic" the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in The Clinic's network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by The Clinic and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I authorize The Clinic to keep my credit/debit/any other card or payment information on a virtual terminal file that is password protected and HIPAA compliant in order to charge all services ordered and/or provided by my provider(s) or for any appointments with The Clinic that are not cancelled 24 hours before the scheduled appointment time to be charged to my stored payment information. Moreover, I authorize The Clinic to charge all pending charges to me on my saved payment modes in the Clinic's file. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As a Harshida J Chaudhari MD PA patient, I voluntarily consent to the rendering of such care and treatment as The Clinic providers and personnel, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and understand I may terminate such visit at any time. My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my The Clinic provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that The Clinic may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from The Clinic. I understand that I may voluntarily "opt-in" to receive automated text message communications from The Clinic and its partners by informing my provider's staff or visiting "My Profile" on my The Clinic Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received The Clinic's Financial Policy and Notice of Privacy Practices. I agree to the terms of The Clinic's Financial Policy, the sharing of my information via HIE/PHI,* and consent to my treatment by The Clinic providers.

Release of information authorization

I have read The Clinic's Notice of Privacy Practices under the Health Insurance Portability & Accountability Act of 1996 containing a more complete description of the uses and disclosures of my health information. I understand that The Clinic has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from The Clinic located at 2225 Williams Trace Blvd, Ste 109, Sugar Land, TX 77478. I understand that I may request in writing that you "The Clinic" restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you "The Clinic" are not required to agree to my requested restrictions, but if you "The Clinic" do agree then you "The Clinic" are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you "The Clinic" have taken actions relying on this consent.

The Clinic may discuss my healthcare, other information pertaining to my care, and/or make financial arrangements with only the following individual's listed below:

_____: None

Name:_____Relationship:_____Phone No:_____

Name:_____Relationship:_____Phone No:_____

Name:_____Relationship:_____Phone No:_____

Printed Name of Patient/Guardian:_____ Email:_____

Signature:_____ Date:_____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

NOTICE OF PRIVACY.PRACTICES
(MEDICAL)

THIS NOTICE DESCHIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. 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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove· it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with. notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of today and we are required to abide by the terms of the Notice of Privacy Practices currently .in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W. Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Signature: _____

Date: _____