

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First Middle Initial Last

Street Address: \_\_\_\_\_  
NO PO BOX PLEASE (street) (city) (state) (zip)

Name of person responsible for payment if other than patient: \_\_\_\_\_

Sex: F M Are you a student? (part-time full-time) Name of School: \_\_\_\_\_

Employed? Yes No Name of Employer: \_\_\_\_\_ If retired, retirement date: \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Marital Status: S M W D

Referring Doctor: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Work Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Emergency contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Name: \_\_\_\_\_ ID or Policy Number \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

Claim Address: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID or Policy Number \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

## INSURANCE PAYMENT AUTHORIZATION AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to Madhavi Kandula, M.D. and acknowledge that I am financially responsible for any unpaid balance. I also authorize Dr. Kandula to release any information requested by my insurance company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You further agree:

1. It is your responsibility to give us the correct information about your insurance company and to follow the rules of your insurance company, such as (i.e.) a valid referral form, precertification, prior authorization in order for your claims to be paid. We will assist you, but if claims are denied because of your failure of the above, you will be responsible for paying the denied service. In the event of non-payment, you will be responsible for any legal and collection fee.
2. You are responsible for paying any deductible, co-payment or non-covered service. Co-payments are due at the time of service.
3. We require 24 hours notice to cancel an appointment. If appointments are not canceled before 24 hours, you will be charged for the missed appointment.

\_\_\_\_\_  
Signature(patient or Parent, if minor)

\_\_\_\_\_  
Date

## MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Please describe main reason for visit: \_\_\_\_\_

Please list medications which you may be allergic: \_\_\_\_\_

Please list all medications you are currently taking. Include *over-the-counter medicines*, **supplements** and those used only occasionally.

Medication	Dose	Frequency
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How much alcohol do you consume in a week?

How much tobacco do you consume in a week?

Have you been diagnosed with, treated for, or received any of the following?

	Please Circle			Please Circle	
Heart Disease	yes	no	Blood transfusion	yes	no
High Blood Pressure	yes	no	Aids or HIV infection	yes	no
Angina or Heart Attack	yes	no	Cold sores or fever blisters	yes	no
Heart Rhythm Disturbance	yes	no	Excessive scarring or keloids	yes	no
Pacemaker	yes	no	Problems with healing	yes	no
Heart Murmur	yes	no	Dizziness or fainting	yes	no
If yes, do you take antibiotics prior to dental procedures	yes	no	Stroke	yes	no
Breathing Difficulties	yes	no	Seizures or epilepsy	yes	no
Bleeding disorder or tendency	yes	no	Psychiatric illness or Emotional problems	yes	no
Kidney disease	yes	no	X-ray exposure or Radiation treatments	yes	no
Diabetes	yes	no	PUBA or UVA light treatments	yes	no
Glaucoma	yes	no	Skin cancer	yes	no
Liver disease	yes	no	If yes, Type                      Location                      Year		
Intestinal Colitis	yes	no			
Hepatitis or yellow jaundice	yes	no			

Please list any other illness below:

Please list any previous hospitalization or surgery with reason and date:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Md. Review



**MADHAVI KANDULA, M. D.**  
**DERMATOLOGY & COSMETIC DERMATOLOGY**

**NOTICE OF PRIVACY PRACTICES**

**THE HEALTH INSURANCE PORTABILITY & ACCOUNTING ACT (HIPAA) REQUIRES EACH PATIENT BE PROVIDED WITH OUR "NOTICE OF PRIVACY PRACTICE." PLEASE SIGN & DATE BELOW. A COPY WILL BE FURNISHED TO YOU UPON REQUEST.**

This notice refers to your personal medical information, as obtained by Madhavi Kandula, M.D. and/or her representative(s). It will include any written information by you, or any data on your behalf by Dr. Kandula or her representative(s).

Our office, under the guidance of HIPAA, takes reasonable and appropriate measures to protect your privacy with your medical records.

**The following are instances where we DO NOT need your separate signed authorization to release medical information:**

For purposes of insurance submission - done via electronic claim submission through an electronic claim clearing house (Gateway EDI, Inc.), or by paper to your insurance carrier via mail-this is for purposes of payment of charges, and will be released only to the insurance carrier(s) you have notified us of.

Separate authorization not needed to disclose protected health information to another health care provider for treatment of the patient.

Separate authorization not needed to fax medical information to another physician's office for treatment purposes (example: pathology, lab report to surgeon's office). Please note that we have in place reasonable and appropriate administrative, technical and physical safeguards to protect material transmitting via fax machine.

Any records as demanded by a state or federal court of law, upon presentation of the appropriate legal documentation.

**We will obtain a separate signed authorization to release from you in the following instances:**

Request for medical information from a new insurance carrier, as in your application for new coverage. This authorization must be current, and very specific as to all medical data or a certain time frame and/or illness.

Separate signed authorization is needed for your request to send copies to another health care provider.

Request for medical information from any legal source, other than that obtained from a court of law with proper documentation (subpoena).



**MADHAVI KANDULA, M. D.**  
**DERMATOLOGY & COSMETIC DERMATOLOGY**

**NOTICE OF PRIVACY PRACTICES**

As a courtesy to our patients, we utilize a phone "reminder service" to remind patients of appointments. It is a computerized voice stating someone at that phone number has an appointment on a certain date at a certain time. If you do not wish us to send out this reminder, please notify any staff member, we will remove your phone number from the computer system. In order to continue to send reminders, we will need the authorization signed at the end of this notice.

The staff of Madhavi Kandula, M.D.P.C., views your medical records only as required in the daily course of operation-specifically to obtain reimbursement from your insurance carrier, third party, or for treatment purposes (correspondence with other medical professionals, laboratories, pathology labs). All safeguards are in place to keep your records from being viewed by unauthorized personnel.

You have the right to inspect, receive copies, and ask for your file to be amended and to obtain an accounting of disclosures. You may also revoke any prior authorization at any time. Any of these requests should be in writing.

All requests will be given to the Office Manager of Madhavi Kandula, M.D.P.C.  
(At this printing-Kristal Meisinger, 314-692-0221).

**PHONE REMINDER AUTHORIZATION:**

I authorize Madhavi Kandula, M.D. and any of her representatives, to use an automated telephone system and/or email and to use my phone number, time and date of appointment for the limited purpose of contacting me to notify of a pending appointment. I also authorize Dr. Kandula or her representatives to disclose to third parties who may answer my phone information regarding pending appointments, and to leave a reminder message on any voicemail system or answering machine.

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

I hereby acknowledge receipt of this notice, having read all of the above, as witnessed by my signature below.

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

I authorize the following family members to receive lab/pathology data, discuss my medical conditions, and make appointments on my behalf: