

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