Dr. Sridevi Siruvella MD

Patient Information

Name:_____ Sex:_____ Age:_____ Birthdate:_____

Address:_____ Marital Status: S M D W

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Social Security#:_____ Occupation:_____

Employer:_____ Work Phone: _____

Employer Address: _____

City:_____ State:_____ Zip Code:_____

Spouse Name:_____ Birthdate:_____ SS#_____

Spouse Employer:_____ Work Phone:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact:_____ Relationship:_____

Phone Number:_____

Insurance Information

Primary:_____ Policy Number:_____

Policy Holder:_____ Birthdate:_____

Secondary:_____ Policy Number:_____

Policy Holder:_____ Birthdate:_____

Were you injured in an accident? Y/N_____ Auto?_____ Work Related?_____ Other:_____

Date of Injury_____

If Work Related, Name of Supervisor & Phone Number:_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of medical records to referring physicians and to my insurance company. I acknowledge full responsible of services rendered. I agree that payment is due at the time of service unless prior arrangements have been made prior to treatment. I will pay all attorney fees and collections costs in the event I default on my payment arrangements. I further authorize that all insurance payments be made directly to Dr Siruvella, MD. Should Dr. Siruvella not be available, I understand that I should go to the nearest emergency room. I have read and fully understand the above consent.

Signature:_____ Date:_____

Dr. Sridevi Siruvella MD

Patient Health History Form

Patient Name:_____ Date of Birth:_____

Your answers on this form will help your clinician understand your medical concerns and conditions better. You don't have to answer any question you feel uncomfortable with. Best estimates are fine if you can't remember specific dates. Thank you.

Present Health Concerns: _____

_____

_____

Medications

Please list your prescribed and non-prescribed medications, vitamins, home remedies

_____

_____

_____

_____

_____

Allergies to medications (please include the type of reaction)

_____

_____

_____

Personal Medical History

Please indicate whether you have had any of the following

___ Congenital heart disease
___ Myocardial Infarction (heart attack)
___ Hypertension (high blood pressure)
___ Diabetes
___ High Cholesterol
___ Stroke
___ Thyroid problemsOther problems:

___ Coagulation (bleeding/clotting)
___ Cancer Type: _____
___ Depression/Suicide attempt
___ Alcoholism
___ Blood transfusion Date:_____
___ Abnormal pap smear Date: _____

_____

_____

DrSiruvella, MD Patient Health History Form

Surgical History (please list all prior operations and dates)
Operation Date
_____
_____
_____
_____

Social History
Do you smoke or chew? YES NO If yes, how much _____packs/day # of years_____
Are you a former smoker? YES NO When did you quit_____
Do you drink alcohol? YES NO If yes, indicate how much _____
Do you use illicit/street drugs? YES NO If yes, please indicate _____
Have you used illicit drugs in the past? YES NO If yes, indicate _____
Do you exercise? YES NO If yes, indicate type/how often_____
Sexually active? YES NO NOT CURRENTLY
Current sex partner(s) is/are: MALE FEMALE
If sexually active, do you practice safe sex? YES NO NA
Birth control method: _____
Have you ever had any sexually transmitted diseases? YES NO
Are you interested in being screened for sexually transmitted diseases? YES NO

Socioeconomics:
Occupation: _____
Education Completed: ___ Grade School ___ High School ___College ___Graduate School
Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed
___Co-habiting ___Engaged ___Other
Spouse/Partners name:_____
Number of Children: _____
Who lives at home with you?_____

Women's Gynecologic History:
Pregnancies ____ Deliveries ____ Abortions ____ Miscarriages _____
Most recent period _____ Age of 1st period _____
Frequency of periods _____ Length of each _____
Do you have concerns about your period? _____
Do you have concerns about menopause? _____

Immunizations
Please check if you received the following vaccine with approximate dates:
Tetanus (Td/Tdap) ___Pneumonia ___ Hepatitis A/B ___
Shingles ___ Influenza (flu) ____

DrSiruvella, MD Patient Health History Form

Family History

Please list your immediate family's health history (blood relatives)

Father_____

Mother_____

Siblings _____

_____

Grandparents _____

_____

Children _____

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my doctor if I have a change in health status.

Patient Signature _____ Date _____

Dr. Sridevi Siruvella MD

512 Great Oaks Dr
Monroe, GA 30655

I hereby give my consent for Dr. Siruvella MD PC to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Dr. Siruvella MD PC describes such uses and discloses more completely and is continually posted on the wall in the waiting room at Dr. Siruvella MD PC.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Siruvella MD PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Siruvella at our office.

With this consent, Dr. Siruvella may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results among others.

With this consent, Dr. Siruvella may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

With this consent, Dr. Siruvella may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as, appointment reminder cards and patient statements. I have the right to request that Dr. Siruvella restrict how she uses or discloses my PHI to carry out treatment, payment, and healthcare operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Siruvella to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Siruvella may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Guardian	Date	Relationship to Patient

_____	_____
Print Patients Name	Print Name of Guardian, if applicable

Dr. Sridevi Siruvella MD

FINANCIAL POLICIES

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Co-payment is due by cash, check, or credit/debit card (Visa, MC, Discover, and American Express) at the time of service unless arrangements have been made in advance.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to Dr. Siruvella (which means have your insurance company pay the doctor directly). If your insurance company does not pay within a reasonable period, we will have to look to you for payment. If we later receive a check from you insurer, we will refund any overpayment to you.
3. If you owe us money due to insurance, we have a loan agreement and promissory note that will allow you to pay Dr. Siruvella off within a 6 month period with 0% interest. Also, the minimum monthly payment has to be $25.
4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits if we are your primary care physician. We will bill them and if required you will pay your co-payment at the time of your visit, per your insurance company.
5. If you are insured by a plan that we do not have a prior arrangement with, we will send the claim for you on an assigned basis. This means the insurer will send payment to you. Therefore, any charges due will be your responsibility at the time of service.
6. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be “not covered” you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office.

Dr. Sridevi Siruvella MD

7. We will bill your insurance company for all services provided by or on behalf of Dr. Siruvella. You are responsible for any balance due.
8. This is to inform you that Dr. Siruvella sends all labs to an outside laboratory (Quest and LabCorp). We will send your insurance information with your labs, however, if your insurance does not cover labs through these companies you will be responsible for the cost of the labs.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Signature:_____ Date:_____

Printed name:_____

Designation of Personal Representative

This form allows you, the patient, to list a maximum of three (3) people you would like to be your personal representative. This allows them to call on your behalf and allows us to speak with them concerning your care. If you prefer to list no one as a personal representative then please fill out your information, check the appropriate box below, sign and date at the bottom.

Patient Name:_____

Date of Birth:_____

Social Security:_____

Patient E-mail:_____

Personal Representative(s)

Name:_____ Phone Number:_____

Address:_____ Relationship to You:_____

Name:_____ Phone Number:_____

Address:_____ Relationship to You:_____

Name:_____ Phone Number:_____

Address:_____ Relationship to You:_____

- Yes, the contacts listed above I give permission to be my personal representative(s).
- No, I do not want anyone to have access to my medical records or information.

Signature:_____ Date:_____

Dr. Siruvella MD MPH
Family Practice – Primary Care
512 Great Oaks Dr
Monroe, Georgia 30655
PH: 770-266-0567 ◊ FAX: 770-266-0507

AUTHORIAZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

□ **Access request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

   _____
   Name of Facility

   _____
   Address

2. The type of information to be used or disclosed is as follows (please include dates of service):
   Dates of Service: _____

□ Complete Medical Record	□ Discharge Summary
□ Abstract of Medical Record	□ X-ray & Imaging Reports
- H&P	□ Operative Reports
- Discharge Summary	□ Progress Notes
- Consultation Notes	□ Laboratory Test Results
- Operative & Procedure Reports	
- EKGs	□ Immunization Records
- Labs	□ History & Physical
- X-ray & Imaging Reports	□ Other: _____

Behavioral Health Reports

□ Social History	□ Treatment Plan
□ Client Data Form	□ Academic History
□ Referral/Treatment Form	□ Aftercare Instructions
□ Admission Evaluation	□ Psychological Evaluation
□ Notification of Admission	□ Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

4. I understand that your facility may receive compensation for medical record copying in accordance with State Law.

5. This information may be disclosed to and used by the following individual/organization:
   Name: _____

   Address: _____

For the purpose of:

□ Future Medical Care
□ Inspection/Copying of my Records
□ Personal
□ Other: _____
□ Insurance Eligibility
□ Legal Investigation or Action
□ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceedings, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C Section 263 (a)), and certain other records.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described above.
8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.
9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and resent my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has been released in response to this authorization. This authorization expires within 90 days, unless otherwise specified.

_____ _____
Signature of Patient (State relationship if not patient) Date

_____
Name (Please Print)

Patient Is: □ Minor □ Incompetent □ Disabled □ Deceased
Legal Authority: □ Custodial Parent □ Legal Guardian □ Executor of Estate (Deceased)
□ Power of Attorney □ Authorized Legal Personal representative

_____ _____
Signature of Witness Date