DILIP TAPADIYA, M.D. INC.

Demographic Form

1. PATIENT

Name _____
Soc Sec No: _____
Street: _____
City: _____ State: _____
Zip: _____ Birthdate: _____
Driver's License No: _____ Sex: _____
Home Phone: (_____) _____
Cell Phone: (_____) _____
Marital Status: _____
Occupation: _____

2. RESPONSIBLE PARTY

Name: _____
Soc Sec No: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____
Relationship: _____

3. NEAREST RELATIVE

Name: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____
Relationship: _____

4. INSURED EMPLOYED BY

Company: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____

5. COVERAGE TYPE:

Cash Only: _____ Yes _____ No
Private Insurance: _____ Yes _____ No
Workers Comp: _____ Yes _____ No
Industrial: _____ Yes _____ No
Lien/Third Party: _____ Yes _____ No

6. PRIMARY INSURANCE

Insured Name: _____
Social Security No: _____
Group or Policy No: _____
Date of Birth: _____
Drivers' License No: _____
Carrier: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____

7. SECONDARY INSURANCE

Insured Name: _____
Social Security No: _____
Group or Policy No: _____
Date of Birth: _____
Drivers' License No: _____
Carrier: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____

8. REFERRAL SOURCE

Name (if doctor): _____
Name (if other): _____
Referring Website: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: (_____) _____

ASSIGNMENT OF BENEFITS:

I directly assign all medical/surgical benefits to DILIP TAPADIYA M.D. Inc. and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor's office to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Sign: _____ Date: _____

DILIP TAPADIYA, M.D. INC.

New Patient Questionnaire

Patient Name: _____
First MI Last Preferred Name

Age: _____ DOB: _____ Weight: _____ Occupation_____

Employer:_____ Workers Comp?: Yes / No

Referring Physician: _____ Town: _____

Primary Care Physician: _____ Town: _____

What brings you in today? (What are your symptoms?)
What side of the body is it? (Right versus left)
Did you have an injury? If so, what/when?
If you have pain, what does it feel like? (Stabbing, sharp, achy, etc)
Does the pain go anywhere?
What makes it feel better or worse? (Positions, medications, etc)
Do you ever get numbness or tinging? (Where?)

Have you had treatment? (Steroids injections, surgeries, therapy)

Medical History:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER: _____		

What surgeries have you had in the past?

1.

2.

3.

4.

5.

Allergies to any medications/Reaction?

Tobacco use? (How much, how often, start/quit date)
Alcohol use? (How much, how often, start/quit date)
Illlicit drugs/marijuana? (How much, how often, start/quit date)
Medical conditions that run in your family? (Condition / relative) 1. / 2. / 3. / 4. /

Review of Symptoms: Please mark any symptoms you are experiencing today or within the past week:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

DILIP TAPADIYA, M.D. INC.

Missed Appointment Policy

Missed appointments both compromise your care and prevent us from offering care to others who could be scheduled in the missed slot.

A missed appointment is when you cancel or do not show for your appointment without at least 24-hour notice.

Below are our fees in the event of missed appointments. Fees still apply even when appointments are rescheduled.

Clinic Missed Appointments:

1. 1st Missed Appointment: $25.
2. 2nd missed Appointment: $35.
3. 3rd Missed Appointment: $45, *possible discharge from practice.*

Physical Therapy and MRI Missed Appointments:

1. 1st Missed Appointment: $40.
2. 2nd missed Appointment: $50.
3. 3rd Missed Appointment: $65, *possible discharge from practice.*

I understand and agree to the missed appointment policy.

Signature _____ Initial _____ Date _____
(Parent/Guardian if applicable)

DILIP TAPADIYA, M.D. INC.

Financial Policy

Dr. Tapadiya and staff would like to welcome you to our practice. Our goal is to provide you with excellent medical care . Our billing policies are outlined below.

1. **Your account is to be kept current; ALL SELF-PAY OR INSURANCE CO-PAYS AND CO-INSURANCES ARE DUE AT THE TIME OF SERVICE**.
2. Payments may be made via cash, check, Visa, Mastercard, Discover, or American Express. Please request a receipt for any payments made via cash or credit card.
3. Returned checks will result in a $25 service charge AND all future payments being required in the form of cash or credit card.
4. If you are not able to provide payment, your appointment may be rescheduled.
5. Every effort is made to send monthly statements to patients; however it is the patient's ultimate responsibility to inquire about any unpaid balances in writing or by calling the office during business hours.
6. Any unpaid balances older than 30 days will be assessed a 1.5% interest charge per month.
7. After 120 days of past-due balance, any unpaid balances will be turned over to a collection agency for collection. You will be responsible for any costs incurred in collection, which may include collection agency fees, court costs, and attorneys' fees. We are not responsible for any adverse actions to your credit rating that may result from collections action.
8. We require a copy of your drivers' license at the initiation of service. **It is YOUR RESPONSIBILITY to notify us of any changes to your address, telephone number, or insurance coverage promptly.** Any unpaid balances resulting from failure to update your information will not be waived.
9. If you have health insurance coverage, we will submit your claims. However, we must emphasize that as a medical provider, our duty is to you and not to your insurance company. Although we attempt to verify benefits with your insurance company, please be advised this is only an estimate of your coverage based on information given to us at the time of the inquiry. Any amounts uncovered by insurance are the patient's responsibility. We will make every effort to assist you with documentation necessary for handling claims.
10. Not all services are a covered benefit with all insurance plans: it is your responsibility to be aware of what services are being provided to you and if they are a covered benefit under your insurance policy. Although filing your claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered. **You are personally responsible for any non-covered charges not payable by your insurance policy**.

We understand financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact our billing department immediately for assistance. **WE ARE HERE TO HELP YOU AND WORK WITH YOU.**

DILIP TAPADIYA, M.D. INC.

Prescription Refill Policy

There are occasions where controlled substances are warranted; however, it is the policy of this office to prescribe them in limited quantities on an as-needed basis based on the clinical judgment of the physician. If you have a condition that you feel requires either large quantities of such medications or long term use of such medications, we will be happy to refer you to an appropriate pain management specialist.

For all prescriptions, narcotic and non-narcotic:

Please note that prescriptions are only refilled during office hours, Mon-Fri 9 AM – 5 PM.
No refills are issued on weekends.

I understand and agree to the prescription refill policy.

Signature _____ Initial _____ Date _____
(Parent/Guardian if applicable)

DILIP TAPADIYA, M.D. INC.

Disability and Work Excuse Forms Policy

Disability and work form requests require significant time on the part of the physician and office staff to complete, as they require parsing through medical records to find exact dates, nature of treatment, exact diagnosis, and other required information.

As such, we charge the following flat fees prior to completing the following forms:

1. State disability forms: $40
2. Private insurance disability insurance forms: $60
3. Work disability forms: $40
4. Family Medical Leave Act (FMLA) forms: $40
5. Handicapped Placard Forms: $20
6. Employer medical leave/time off forms: $40
7. Third party medico-legal reports: $40-60, depending on complexity

Forms may be left with the office at the time of appointment, and will be available for pickup within 7-10 days. We regret that we cannot fill them out at the time of service, as time needed to fill these forms can signfiicantly delay office operations and cause subsequent patient appointments to be delayed.
We do not charge for school/physical education excuse notes.

I hereby certify that I understand and agree to the charges for forms.

Signature _____ Initial _____ Date _____

DILIP TAPADIYA, M.D. INC.

Records Release

We cannot discuss your protected health information (PHI) with anyone other than yourself without your written consent.

Please list below the name(s) of individuals you authorize our office to discuss your care with, either in person, via phone, or via mail. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing. This authorization may be modified at any time.

Name	Relationship to patient
_____	_____
_____	_____

Signature _____ Initial _____ Date _____
(Parent/Guardian if applicable)

Duplication Policy

Due to costs of toner/paper/labor/postage, we regret that we must charge a fee to copy records as allowed by California law. California law allows a 15-day turnaround for records requests.

- To send records to a third party OR to a patient themselves, a signed record release request (above) is required.
- Please note that outside records are not released under any circumstances—these must be obtained from the facility at which they were generated.

Whether records are being sent to the patient or to a third party, fees are as follows pursuant to California Health and Safety Code Section 123100:

1. Medical chart notes: $6.00 per 15 minutes of time spent in duplication, plus $0.25 per page
2. Xrays and MRI: $6.00 per 15 minutes of time spent in duplication, plus $17 per x-ray film to be copied, or $25 per MRI CD to be made. Original films are not released under any circumstances.
3. Postage: We do charge for actual postage when records are requested to be mailed.

I certify that I understand and agree to the records policy.

Signature _____ Initial _____ Date _____

DILIP TAPADIYA, M.D. INC.

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have been provided an opportunity to review a Notice of Privacy Practices (electronic copy available on website, hard copy available on request).

Printed Name _____

Signature: _____

Date: _____

Insurance Authorization and Assignment

I authorize Dilip Tapadiya, M.D. Inc. to furnish all information to insurance carriers concerning my illness, and/or treatments, and I assign to Dilip Tapadiya, M.D. Inc. all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit. This includes co-pays and co-insurance, as well as any other uncovered amounts. I understand that I am responsible for notifying Dilip Tapadiya M.D. Inc. of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be held responsible for these charges.

Signature: _____ Initial: _____ Date: _____
(Parent/Guardian if applicable)

Acknowledgement of and Agreement to Office Policies

I acknowledge that I am aware of Dr. Tapadiya's office policies and agree to the following:

1. Missed Appointment Policy
2. Prescription Refill Policy
3. Financial/Billing Policy
4. Disability and Work Excuse Forms Fee Policy
5. Records Request Fee Policy

Signature: _____ Initial: _____ Date: _____
(Parent/Guardian if applicable)