SATISH ANGRA MD, PC

BOARD CERTIFIED IN INTERNAL MEDICINE AND BOARD ELIGIBLE IN PEDIATRICS

PATIENT REGISTRATION

PATIENT NAME FIRST MIDDLE LAST				DATE OF BIRTH
HOME ADDRESS		CITY	STATE	ZIP CODE
OCCUPATION EMPLOYED ☐ RETIRED ☐ STUDENT ☐	SOCIAL SECURITY NO.	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	SEX	HOME PHONE
EMPLOYER	E-MAIL	WORK PHONE		CELL PHONE
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE		
RACE: ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ OTHER ☐				

PIP INFORMATION

SUBSCRIBERS FIRST NAME LAST NAME		HOME PHONE		RELATIONSHIP TO PATIENT
HOME ADDRESS		CITY	STATE	ZIP CODE
PRIMARY INSURANCE COMPANY NAME:		POLICY NUMBER		CLAIM NUMBER
INSURANCE COMPANY ADDRESS:		ADJUSTER NAME		ADJUSTER PHONE NUMBER

THIRD PARTY INFORMATION

THIRD PARTY INSURANCE COMPANY NAME	POLICY NUMBER	CLAIM NUMBER
INSURANCE COMPANY ADDRESS	ADJUSTER NUMBER	ADJUSTER PHONE NUMBER

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claim, to the above named billing agent.

1. I agree to have my insurance company, Medicare or third-party payment program make payments directly to SATISH ANGRA MD, PC.
2. I agree to let my doctor(s) and the office of SATISH ANGRA MD, PC submit claims and required treatment information to my Insurance company, Medicare or other third-party payment program for my care and receive payments directly.
3. I understand that I must pay all charges, co-payments and deductibles that are not covered by my insurance company, Medicare or third party payment program.

Patient Signature (or person authorized to sign for patient)_____

Relationship to Patient_____ Date_____

_____

Authorized Staff Signature Date

Account

NAME:_____

1. Please describe your accident? (How and what happened)_____

_____

2. Did any parts of your body strikes or any part of your car causing injury? Explain_____

_____

3. What date did the accident occur?_____
4. Did you go to hospital? If yes, which hospital_____
5. What testing did you have done? _____
6. Have you returned to work? Yes □ No □
7. Date you returned to work. _____
8. Do you currently have a lawyer for this accident? Yes □ No □
9. Lawyer Name: _____ Phone #_____

   Lawyer Address:_____

Medical information

Please list any **MEDICATIONS** you are currently taking, Prescribed or over the Counter:

Medication	Dosage	Route	Frequency

Please List Any **SURGERIES** you have had and include the month/year.

_____

_____

Social Information

Tobacco Use:

- Do You Smoke Yes □ No □
- How many Cigarettes per day:_____
- No. of years smoking:_____
- Have you quit before? _____
- **Alcohol use:** Do you drink Alcohol? Yes □ No □ If yes, how many drinks per occasion/day/month:_____
- **Drug Use:** Any History of illegal drug use? Yes □ No □ What Type? _____

SATISH ANGRA MD, PC
10801 LOCKWOOD DRIVE
SUITE #280
SILVER SPRING, MD 20901
PHONE# 301-593-3400
FAX# 301-681-0715

ASSIGNMENT AND AUTHORIZATION

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocable assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of the personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. I also understand that if I have an HMO Health insurance, the services will not be billed to my Health Insurance and that I will be responsible for all the bill that are not paid by my PIP or by Liability Party. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all PIP, Med-Pay, or Med-Expense payments.

It is further understood that the statute of limitations in this state is three (3) years from the time said services were last performed and I further understand that because of long delays in trial dockets, many cases are not tried or settles until a date which is beyond three (3) years after the last services was performed. In View of this, I hereby agree that the statue of Limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by me of any balances claimed to be due and owing to you by me.

Signature:_____

Relationship to Patient:_____

Witness:_____ Date:_____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING “AUTHORIZATION AND ASSIGNMENT” AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATS OF THE CLAIM OF THE PATIENT WITH IN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENTS THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

_____
ATTORNEY SIGNATURE

_____ _____
ATTORNEY NAME DATE

SATISH ANGRA MD, PC
10801 LOCKWOOD DRIVE
SUITE #280
SILVER SPRING, MD 20901
PHONE# 301-593-3400
FAX# 301-681-0715

LETTER OF AUTHORIZATION AND ASSIGNMENT

I_____ hereby authorize and direct my attorney and/or insurance companies, upon receipt of medical reports and/or itemized statement to pay:

SATISH ANGRA MD, PC
10801 LOCKWOOD DRIVE
SUITE #280
SILVER SPRING, MD 20901

For services and treatments rendered to me for my AUTOMOBILE ACCIDENT on _____.
Date of accident

It is also understood and agreed that nothing herein relieves me of the primary responsibility and obligation of paying you for said services rendered.

I waive all statutes of Limitation.

Signed_____
(Signature of parent/guardian if patient is minor)

Date_____

Witness_____

Date_____

AUTHORIZATION FORM

SATISH ANGRA MD, PC

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **SATISH ANGRA MD, PC** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits **SATISH ANGRA MD, PC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire when written notice is provided by me.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **SATISH ANGRA MD, PC**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **SATISH ANGRA MD, PC** 10801 LOCKWOOD DRIVE SUITE #280, SILVER SPRING, MD 20901

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

PATIENT CONSENT FORM

SATISH ANGRA MD, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **SATISH ANGRA MD, PC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **SATISH ANGRA MD, PC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

SATISH ANGRA 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 **SATISH ANGRA MD.**

With this consent, **SATISH ANGRA MD, PC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **SATISH ANGRA MD, PC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **SATISH ANGRA MD, PC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **SATISH ANGRA MD, PC** restrict how it uses or discloses my PHI to carry out TPO. 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 **SATISH ANGRA MD, PC** to use and disclose my PHI to carry out TPO.

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, **SATISH ANGRA MD, PC** may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Print Patient's Name	Date

_____

Print Name of Patient or Legal Guardian, if applicable
