Ashvini Health Services

Bela A. Patel, M.D.

Telephone: (609) 586-0300 Fax: (609) 586-0325

PRIMARY OFFICE
54 Robbinsville-Allentown Road
Robbinsville, NJ 08691

SECONDARY OFFICE
2271 State Highway 3, Suite 110
Hamilton, NJ 08690

-Patient Information-

Last Name: _____ First Name:_____ M.I. _____
Address:_____
City:_____ State:_____ Zip Code:_____
Date of Birth:_____ Age:____ Sex: Male_____ Female_____ Social Security Number: _____
Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Separated_____
Race: ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/ African America ☐ Hawaiian native/ Pacific Islander ☐White ☐Unknown
Ethnicity: ☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino ☐ Unknown
Home Phone:_____ Mobile Phone:_____ Work Phone:_____
Patient Employed by: _____ Occupation:_____
In Case of Emergency who should be notified:_____ Phone:_____
Whom may we thank for referring you?_____
Pharmacy: _____ Phone Number: _____

-Primary Insurance-

Insurance Company:_____
Subscriber ID #:_____ Group #:_____
Person Responsible for account:_____
Relation to Patient:_____ Date of Birth:_____ Soc. Sec.#:_____
Address(if different from patient):_____
City:_____ State:_____ Zip Code:_____

-Additional Insurance-

Is patient covered by additional insurance? ☐ Yes ☐No

Insurance Company:_____
Subscriber ID #:_____ Group #:_____
Person Responsible for account:_____
Relation to Patient:_____ Date of Birth:_____ Soc. Sec.#:_____
Address(if different from patient):_____
City:_____ State:_____ Zip Code:_____

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-Assignment and Release-

I, undersigned certify that I (or my dependent) have insurance with _____ and assign directly to Dr. Patel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

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RELEASE OF RECORDS AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST MY MEDICAL RECORDS SENT TO:

Ashvini Health Services

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Robbinsville, NJ 08691
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Patient Name:_____

Date of Birth:_____

Address:_____

Date:_____

Signature:_____

Previous Doctor's Information:

Name:_____

Address:_____

Phone Number:_____

Fax Number:_____

Our Payment Policy

Thank you for choosing Ashvini Health Services. We are committed to provide you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services

rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided. A copy will be provided for you upon request.

1. Insurance: We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit or within 14 days of billing statement. If you are insured by a plan we are participating with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage or within 14 days of billing statement. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patient can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

3. Proof of insurance: All patients must complete our form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim

4. Claim submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. You insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays the claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. Coverage changes: In your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive maximum benefits. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you.

6. Nonpayment: if your account is over 30 days past due, you will receive a statement. All Statements are due within 14 days of the statement date. A finance charge will be accessed to all accounts that are over 60 days past due. Partial payments will not be accepted unless previously negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a National Collection Agency, litigate in a court of law (other legal fees may apply) and charge a service fee of $30.00.

7. Appointment Cancellation Policy: If you are unable to keep a scheduled appointment, please notify the office no later than 12 hours prior to your scheduled appointment time. If you do not notify our office we reserve the right to charge a $30.00. This fee is not covered by your insurance and will be payable prior to any further appointments being scheduled.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understood the payment policy and agree to abide by its guideline:

Name: _____ Signature: _____Date: _____

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PATIENT RECORD OF DISCLOSURES

In General the HIPAA policy rule gives individuals the right to request restriction on uses and disclosures of protected health information (PHI). This Individual is also provided the right to request confidential communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of individuals home.

I wish to be contacted in the following manner (check all that applies):

☐Home Telephone: _____
☐OK to leave message with detailed information
☐Leave a message with call back number only

☐Written Communication:_____
☐OK to mail to my phone address
☐OK to mail to my work/office address

☐Work Telephone:_____
☐OK to leave a message with detailed information

☐Cell Phone:_____

☐ Email: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The privacy rules generally requires healthcare providers to take responsible steps to limit the use or disclosure of and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax	(*1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(*2)	(*3)

(*1) Check this box if disclosure is authorized
(*2) Type KEY: T=Treatment Release; P=Payment Information; O=Healthcare Operations
(*3) Enter how the decision was made; F=Fax; P=Phone; E=Email; M=Mail; I=In Person or O=Other

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Name:_____

Date:_____

TO SERVE OUR PATIENTS NEEDS MORE EFFICIENTLY

1. All refills require 3 days' notice, preferably 1 week before medications are finished.

2. All referrals are processed only on Fridays, exceptions for Emergencies Only.

3. All Special Diagnostic Tests authorizations are done of Fridays, exceptions for Emergencies Only.

4. Cancellations for Appointments must be made 24 hours in advance to avoid a cancellation fee

5. There will be a no-show appointment fee of **$30.00.**

NO EXCEPTIONS

_____

Patient Signature

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Name: _____ Sex: ☐M ☐ F Todays date: _____
Age: _____ Date of Birth: _____ Date of last physical examination: _____
Address: _____
Best Phone Number: _____ E-Mail address: _____
Emergency Contact Name: _____ Phone Number: _____ Relationship: _____
Occupation: _____ Work Phone: _____ Employer: _____
Languages: _____ Preferred Language: _____

1. **What is your reason for visit?** _____
2. **Past Medical History:**

   _____
   _____
3. **Past Surgical History (include year):**

   _____
   _____
4. **Medications:**

   _____
   _____
5. **Hospitalization:**

Year	Hospital	Reason

6. **Allergies (food, medicine, or seasonal):**

   _____
   _____
7. **Family History:**

Relation	Age	State of Health	Age at Death	Cause of Death	Check if, your blood relatives had any of the following: Disease Relationship to you		
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brother						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Stroke	
Sister						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

8. **Social history:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐Divorced ☐ Other ☐Children #_____
ETOH Use: ☐ Past ☐ Present Tobacco Use: ☐ Past ☐ Present
Recreational Drug Use/ Abuse: ☐Past ☐ Present
Smoking: ☐Past ☐Present Substance Smoked_____ Qty.: _____

9. **Pregnancies:**

Year of Birth	Sex of Birth	Complications, If any	Menarche:
			Miscarriages, if any_____
			Use of oral contraception pills: ☐Y ☐N
			Hormone Replacement Therapy: ☐Y ☐N
			Menopause: ☐Y ☐N If yes, then at what age_____

10. **EOL Documents:**

Living Will/ POLST: ☐Yes ☐ No	**Provided?** ☐Yes ☐No
Health Care Proxy: ☐Yes ☐ No	**Proxy Name:**
Code status:	**Proxy Telephone Number:**

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General	**Vascular**	**MEN Only**
☐ Fever	☐ Claudication	☐ Breast Lump
☐ Chills	☐ Swelling of Legs	☐ Erection Difficulties
☐ Change in weight	☐ Coolness	☐ Lump in Testicles
☐ Fatigue	☐ Loss of Hair	☐ Penis Discharge
☐ Sweats	☐ Discoloration	☐ Sore on Penis
☐ Appetite	☐ Ulcer	☐ Other
HEENT	**Genitourinary**	**GYN System**
☐ Headache	☐ Frequency	☐ Dyspareunia
☐ Fainting	☐ Urgency	☐ Birth control Methods
☐ History of head injury	☐ Hesitancy	☐ Age of Menarche
☐Use of Eyeglasses	☐ Nocturia	☐ Interval between Periods
☐Change in vision	☐ Incontinence	☐ Durations of Periods
☐ Photophobia	☐ Pain in Urination	☐ Amount of Flow
☐Double Vision	☐ Burning	☐ Date of last Period
☐ Glaucoma	☐ Blood in urine	☐ Metrorrhagia
☐ Cataracts	☐ Urine Color	☐ Grav____Para____AB_____
☐Hearing Impairments	☐ Urine odor	☐ Dysmenorrhea
☐ Tinnitus	☐ discharge	☐ Menopausal Symptoms
☐ Nosebleeds	☐ Impotence	☐ Post-Menopausal Bleed
☐ Sinus infections	☐ Scrotal Masses	**WOMEN ONLY**
☐ Frequent Sore throat	☐ Hernias	☐ Hot Flashes
☐ Postnasal Drip	☐ History of STD	☐ Abnormal Pap Smear
☐ Discharge: eyes, ear, nose		☐ Nipple Discharge
		☐ Painful Intercourse
		☐ Vaginal discharge
Neurologic	**Gastrointestinal**	**Integumentary**
☐ Dizziness	☐ Nausea	☐ Rashes
☐ Strokes	☐ Vomiting	☐ Itches
☐ Numbness	☐ Difficulty Swallowing	☐ Hives
☐ Tingling	☐ Heartburn	☐ Changed in skin color
☐ Weakness	☐ Abdominal Pain	☐ Changed in hair texture
☐ Tremors	☐ Diarrhea	☐ Changes in nail textures
☐ Loss of memory	☐ Constipation	☐ History of previous skin disorders
☐ Unsteadiness of Gait	☐ Stool Color _____	☐ Bruise Easily
☐ Seizures	☐ Stool Caliber _____	**Hematological**
	☐ Stool Consistency _____	☐ Anemia
	☐ Vomiting up Blood	☐ Bleeding Tendencies
	☐ Rectal bleeding	☐ Blood Transfusions
	☐ Black, Tarry Stools	☐ Easy Brusiability
	☐ Jaundice	☐ Lymphadenopathy
Respiratory	**Breasts**	**Musculoskeletal**
☐ Cough	☐ Lumps	☐ Muscle Stiffness
☐ Shortness of breath	☐ Discharge	☐ Muscle Cramps
☐ Sputum Production	☐ Pain	☐ Joint Pains
☐ Coughing up blood	☐ Tenderness	☐ Joint Stiffness
☐ Wheezing		☐ Arthritis
		☐ Back Pain
		☐ Limitation of Movement
Cardiac	**Vaccinations**	**Endocrine**
☐ Chest Pains	☐ TDAP	☐ Heat or cold intolerance
☐Palpitations	☐ PPO	☐ Hoarseness
☐ Orthopnea	☐ Shingles	☐ Voice Changes
☐ PND	☐ Pneumococcal	☐ Excessive Hunger
☐ SOB with Exertion	☐ Meningococcal	☐ Excessive thirst
☐ Heart Murmur		☐ Goiter