DESERT ROSE MEDICAL CONSULTANTS, PC
PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION ACCURATELY OTHERWISE YOU WILL BE BILLED

PERSONAL INFORMATION

LAST NAME:	**FIRST NAME:** **MIDDLE INITIAL:**
DATE OF BIRTH:	**SOCIAL SECURITY NUMBER:**
STREET ADDRESS:	
CITY: **STATE :**	**ZIP CODE:**
HOME PHONE:	**WORK PHONE:**
CELL PHONE :	**MARITAL STATUS:**
EMERGENCY CONTACT:	**PHONE #:**

INSURANCE INFORMATION

PRIMARY INSURANCE: **HMO / PPO**	**SECONDARY INSURANCE:** **HMO / PPO**
Name Of Insurance:	**Name Of Insurance:**
Name of Insured:	**Name of Insured:**
Member #:	**Member #:**
Group #:	**Group #:**

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS & DRIVER LICENSE/OTHER FORM OF IDENTIFICATION

GUARANTOR/PARENT/INSURED INFORMATION : (If different from patient above)

Name:	**SSN:** **DOB:**
Address:	**Relationship to patient:**
Phone#:	**Employer Name:**

ARE YOU EMPLOYED? Yes No If employed, then provide:

Employer:	**Phone No.:**
Address:	

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plan to Desert Rose Medical Consultants, PC

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all the charges including, but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release all information to secure the payment.

*Signed:*_____*Date:*_____

Parent or Guardian (If Minor)

Desert Rose Medical Consultants, P.C.
10320 W. McDowell Rd, N1445
Avondale, AZ 85392

Phone : (623) 547-2100
Fax : (623) 547-3005

Patient Communication

Patient Name:_____ Date of Birth_____

We must call on occasions to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like us to get this information to you:

	Okay to call my home and leave a message.
	Call my home phone but do not leave messages.
	Call me on my cell phone. Leave a message? _____Yes_____No
	Cell Ph # ( ) _____ - _____
	Do not speak to family members.

I give permission only to the following individuals listed below to receive protected health information:

_____
_____
_____
_____

_____ _____
Signature **Date**

Desert Rose Medical Consultants, P.C.
Insurance Coverage Waiver

I understand that if my eligibility for coverage by the stated Insurance cannot be confirmed at this time. I still wish to receive medical services from Desert Rose Medical Consultants, PC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ _____
Signature of Patient/ Legal Guardian **Date**

Desert Rose Medical Consultants, P.C.
Acknowledgement of Notice of Privacy Practices

I acknowledge receipt of Desert Rose Medical Consultants, P.C. Notice of Privacy Practices

_____ _____
Signature **Date**

Desert Rose Medical Consultants, PC Financial Policy

Thank you for choosing Desert Rose Medical Consultants, PC as your healthcare provider. We are dedicated to providing the best possible care for you. We want you to completely understand our financial policies as it is important to our professional relationship. Please ask if you have any questions. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information etc.)

Please read carefully

PATIENT RESPONSIBILITY:

Your Co-payment, Co-insurance or Deductibles are your responsibility. All patients are expected to present an insurance card at each visit. **All co-payment, co-insurance, deductibles and past balances are due at the time check in.**

If you have deductibles that have not been met then then our policy is to charge $75-150 at the time of the visit. You will be billed for any residual balance as determined by your insurance.

If you are unable to pay your co-payment, co-insurance or deductible, your appointment may be rescheduled unless you have made prior arrangement. **Any amount not paid at the time of service is subject to an additional fee of $25.00 to cover billing cost.** This fee will be waived if payment is made within 5 days. We urge you to help keep our administrative costs down so we can focus on providing quality medical care. Any denial(s) for service(s) not covered under your policy remain your responsibility.

INSURANCE:

1. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim if you assign the benefits to the doctor. In order to file your claim, we require that you disclose all insurance information including primary and secondary insurance**.** Failure to provide complete insurance information may result in patient responsibility for the entire bill**. Acceptable insurance identification is defined as a valid insurance card. If your insurance company does not pay the practice within a reasonable period of 45 days from the date of billing, we will bill you for payment.** If, we later receive a check from your insurer, we will refund any overpayment to you.

2. Desert Rose Medical Consultants will bill only contracted insurance plans. **If a non-contracted insurance company covers you, full payment is required at the time of service.** We will provide you with an itemized statement. You would need to submit the claim to your insurance company for direct reimbursement to you.

3. Not all insurance plans cover all services; such as vaccines etc. that are deemed necessary by your physician. **In the event your insurance plan determines a service to be "non-covered," you will be responsible for the complete charge.** Payment is due upon receipt of a statement from our office.

MISSED APPOINTMENTS : There will be a charge of $25 for any missed appointment. (All No shows and failure to give at least 24 hrs notice of cancellation/ rescheduling is considered "Missed appointment")

SELFPAY: The full amount is due at the time of service unless payment arrangements are made in advance.

DISHONORED CHECKS: Dishonored checks will be subject to a $25.00 service fee. Dishonored checks not redeemed within 20 days of written notice to the maker will be referred to the County Attorney's office for enforcement of bad check laws. You **will** be placed on a cash only basis following any returned check.

DELINQUENT ACCOUNTS: Delinquent accounts may be assigned to a collection agency or attorney. Additional fees including collection, attorney's fees and interest at 2% per month will be added to the total amount due.

MEDICAL RECORDS: Patients requesting copies of medical records will be charged $35.

OUTSTANDING BALANCE POLICY: It is our office policy that all past due accounts be sent three statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs and other additional costs as noted above for delinquent accounts.

RECEIPTS provided to you at time of visit for any payments will be your proof of payment. Please keep these carefully**.**

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: _____

Name: _____

Desert Rose Medical Consultants, PC

Veena Gulaya, MD
Devendra Gulaya,MD

Welcome to our practice.

NAME		**DOB :**	**SEX : M F**
PHONE		**MARITAL STATUS**	
OCCUPATION		**EDUCATION**	
EMERGENCY CONTACT		**PHONE NO.**	
NAME OF LAST PHYSICIAN		**LAST SEEN**	
PHARMACY NAME:		**PHARMACY PH NUMBER :**	

PLEASE TAKE A MOMENT TO COMPLETE THE MEDICAL HISTORY SO WE CAN TREAT YOU MORE EFFECTIVELY-You may use back side of this page for additional space. Please sign and date pages 2-3

Today's visit is for:_____

If we have time, I'd also like to discuss:_____

Medications / Medical History

☐ **NONE**

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

☐ **NONE** ❑ High Blood Pressure ❑ Diabetes ❑ High Cholesterol _____ ❑ Heart Problems: _____ ❑ _____ ❑ _____	❑ Prostate Problems ❑ Depression ❑ Stomach/GI problems:_____ ❑ Cancer, type:_____ ❑ _____ ❑ _____ ❑ _____ ❑ _____

ALLERGIES YES NO If yes, then complete below

NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:

TYPE OF SURGERY	SURGEON	HOSPITAL	DATE

HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)

REASON	DOCTOR	HOSPITAL	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	*Family Members affected and exact nature of problems*
❑ Diabetes	
❑ High Blood Pressure	
❑ Heart Problems	
❑ Cancer	
❑ High Cholesterol	

SOCIAL HISTORY / HABITS

❑ **Smoker**: _____ packs/day ❑ Non-smoker ❑ Quit smoking in _____
Alcohol use: ❑ Yes (drinks/week:_____) ❑ No
❑ **Substance Abuse** _____
❑ I **exercise** regularly ❑ I exercise rarely ❑ I do not exercise
❑ I **have/ have** not traveled outside the United States in the past three months

HEALTH MAINTENANCE

Last Physical/Pap/Prostate	Eye Exam	Dental Exam
Last Tetanus Shot	Pneumonia Shot	Hepatitis B Immunization
Last Mammogram	Bone Density	
Last Colorectal Cancer Screening Colonoscopy/Flex Sig :		

OBSTETRIC HISTORY

No of Pregnancies	Method of Birth Control (If any)

How did you hear about us?_____

NAME _____SIGNATURE_____DATE_____

Advanced Directives ☐ Yes ☐ No If yes, then please provide a copy

PLEASE TAKE A MOMENT TO ANSWER THESE IMPORTANT QUESTIONS -Mandatory

Have you been discharged from any practice? YES/NO
If yes, then reason -

Narcotic Policy
As a rule per our office policy we do not prescribe controlled substances without proper documentation from previous physician of appropriate compliance related to those medications.
You are responsible for providing that documentation. **You may need to reschedule your appointment till that documentation is available.**

Is any of your medical condition(s) secondary to workman's compensation or accident injury? YES/NO
If yes, give details:

DO you have any ongoing/ pending medico-legal litigation? YES/NO
If yes, give details:
Are you on Medical Disability? YES/NO_____

Please note that we do not do any medical disability evaluations/assessments and accident related injury evaluations and treatment. If you are here for that reason then you may need to see a different physician that does such evaluations.

Please list all physicians you are currently seeing

Name	Specialty	Reason	Last seen

NAME _____SIGNATURE_____DATE_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the Physician/ Organization stated below to release my medical records -

PHYSICIAN/ PRACTICE		Phone #	
	Address	Fax	
Date of Service	**From**_____	**To**_____	
INFORMATION	**X All Pertinent Medical Reports**	**X Lab Reports**	**X Other**
PURPOSE	**For Continuing Medical Care**		
	□ Other (specify reason)_____		
INFORMATION TO BE SENT TO	**Desert Rose Medical Consultants, P.C.**	**Veena Gulaya, MD/ Devendra Gulaya, MD**	
	10320 W McDowell Rd, N1445 Avondale, AZ 85392 Address Zip Code	**(623) 547-2100 (623) 547-3005** Phone Fax	

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

If I refuse to sign this authorization form. I understand that Desert Rose Medical Consultants, P.C. holds the right to not accept me into their practice.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, it will expire 6 months from the date signed or as specified:_____

I release the above noted agency, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

PATIENT INFORMATION	Patient Name	Date of Birth	
	Address	Phone #	

Signature of Patient	Date	If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign. (separate release form)
Signature of Legal Representative	Relationship to Patient **or** Description of Authority to Act for Patient	

DATE FAXED _____ **INITIALS**_____