Nehal Ghevariya MD PC 15035 E 14th St, STE G San Leandro, CA 94578
Phone: 510-357-8180 Fax: 510-357-0276 www.primaryphysician.org

Age: _____ Date of Birth: _____Driver's License#_____Social Security#_____
Name:

_____
First Middle Last

Home Address: _____City_____State_____Zip_____

Email Address: _____ Phone: (_____) _____

Cell: (_____) _____ Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widower

Employer: _____Phone: _____

Work Address: _____Occupation: _____

Spouse: _____Date of Birth: _____

Employed by: _____Social Security # _____

Contact Person to Notify in Emergency: _____Relation: _____

Address: _____Phone: _____

RESPONSIBLE PARTY FOR PAYMENT (If other than self)

Name: _____Date of Birth: _____

Social Security # _____ Phone: _____

Home Address: _____

Work Address: _____

Work Phone: _____ Occupation: _____

INSURANCE INFORMATION Insurance Company_____

Policy#_____ _____ Medicare_____

I, the undersigned, have insurance coverage and with the above named carriers, and assign directly to: Nehal Ghevariya MD, PC all surgical and/or medical benefits including any major medical benefits if any, otherwise payable to the corporation for services rendered. I understand that I am financially responsible for all charges whether or not paid by my health insurance. I am fully responsible for all charges/fees for consultations, investigations, blood/imaging/other tests. I hereby authorize the physician to release all information necessary to secure the payment of benefits.

DATE: _____SIGNED: _____ **(Continue to Page 2)**

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Office Policies

• Co-payments are due at the time of visit, payable by cash or check ONLY. An additional $10 fee will be charged if we have to bill you for any co-payment.

• You are fully responsible for paying all the fees/charges incurred for imaging tests, blood tests, consultations and any other charges related to your care.

• Please make your checks payable to: **Nehal Ghevariya MD, PC**.

• There will be a $25 service charge for all returned checks. After two returned checks, all payments must be made in cash.

• If you need to cancel or reschedule your appointment, please give us at least 24 hours notice. We reserve the right to discharge a patient from our practice for not following with us as recommended.

• Prescription refill should be requested during regular office hours. You may also call your pharmacy for a refill arrangement. Request for refills must be made at least seven business days in advance.

• There will be minimum $30 charge for any outside forms that need to be completed by us. This includes DMV form, disability forms, jury-duty excuses etc. Complex and lengthy forms may require a higher charge.

• Please allow at least seven business days for form completion once submitted and you make appropriate payment. Complex and lengthy forms may require extra processing time.

• DMV physical examination fee is $250.00.

• Fees are subject to change without prior notice.

Please feel free to let us know if you have any questions. Your signature below states that you understand our office rules.

_____ _____

Patient/Representative/Guardian Signature Date

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Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist during your visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, time spent, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our receptionist. You must mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support your request. We may also deny your request if:

- We did not create the information, or the person who created it is no longer available to make the amendment,
- The information is not part of the record, which you are permitted to inspect and copy,
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider
- The information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations: For example- you could request that we do not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for your care. Your request must be made in writing to our practice manager. We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment. DATE:_____SIGNED:_____**(Continue to Page 4)**

Accounting Disclosures. You have the right to request a list of disclosures of your health information we have made outside of our practice that were not for treatment, payment or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example- you may request that we call you only at your work number, or by mail at the special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

Ways in Which We May Use and Disclose Your Protected Health Information:
The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example- we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment: We will use and disclose your protected health information to obtain payment for the health information to support the business activities of our practice. For example- we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates, who perform billing, consulting, record keeping, and transcription services for our practice and state/federal regulatory agencies. Your signature below indicates that you have read and understood all of the above information and agree to comply with our policies.

_____ _____
Patient/Representative/Guardian Signature Date