*PATIENT’S AUTHORIZATION*

**Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, ST, ZIP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Soc Sec:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of Contact:

* **Phone** (Cell, Home or Work)
* **Email** Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Our Prescriptions are done electronically; please list the pharmacy that you use most**

Store or Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Store ID number: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City or Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to E-Med Hx download from Pharmacy Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

(This allows us to download your Medication history directly from your pharmacy)

**Only if Insurance cards are not present**

**Primary** Insurance Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay: $\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary** Insurance Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay: $\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check All that apply to each individual person **If Living If Deceased**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Cancer (Type) | Diabetes | High Blood Pressure | Stroke | Mental Illness | Heart Disease |  | **Age** | **Health (Good, Fair, bad)** | **Age of Death** | **Cause** |
| Father |  |  |  |  |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |  |  |  |  |
| Maternal Grandmother |  |  |  |  |  |  |  |  |  |  |  |
| Maternal Grandfather |  |  |  |  |  |  |  |  |  |  |  |
| Paternal Grandmother |  |  |  |  |  |  |  |  |  |  |  |
| Paternal Grandfather |  |  |  |  |  |  |  |  |  |  |  |
| Aunt(s) or Uncle(s)  Label Maternal or Paternal |  |  |  |  |  |  |  |  |  |  |  |
| 1. |  |  |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |  |  |  |
| Brother(s)/sister(s) |  |  |  |  |  |  |  |  |  |  |  |
| 1. |  |  |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient Medical History** | | | | | | |
| **Check any Illnesses or conditions you have had:** □ Diabetes □ Heart Trouble □Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Asthma □Tuberculosis □Kidney Disease □Rheumatic Fever □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Allergies/ Reactions (List any you to foods or medications:  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Do you currently smoke?  □No □Yes | In the Past?  □No □Yes | | Type and Daily amount: | How many years have you been a smoker?  Or, How long ago did you quit? | | |
| Do you currently use and illegal drugs? | □No □Yes | | What kind? | Used in the past? | | |
| **Do you Use Alcohol Beverages?**  □No □Yes | | **Type:** | | | **Weekly amount:** | **How Long?** |
| **Do you Drink Coffee?**  □No □Yes | | | | | **Weekly amount:** | **How Long?** |
| * Surgeries or Hospitalizations (List and give approximate dates)   □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Prescription Medicines/ Drugs   (List any being taken now that were prescribed by a doctor or dentist. Include what you take for chronic conditions, birth control, etc.)  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Non-Prescription Medicines / Drugs   (List any you sometimes take that were bought without a prescription, such as Aspirin. antacids, sleep medicine, allergy, cold medicine, vitamins, ect.)  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

What is your main problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main symptom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Symptoms:

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Pain
* Pressure
* Tightness
* Radiation
* Palpitation
* Indegestion
* Shortness of breath

Relief of symptoms:

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Rest
* Position
* Antacids
* Nitrates
* Belching

**SRIDHAR CHATRATHI, MD, FACC, FSCAI, FACP**

*Diagnostic & Interventional Cardiovascular Medicine*

|  |  |  |
| --- | --- | --- |
|  | 7500 HANOVER PARKWAY,  STE 105A  GREENBELT, MD 20770 TEL: 301-220-2220 FAX: 301-220-2224 |  |

**FINANCIAL POLICY/ COLLECTION POLICY**

Full payment is due at the time of each visit unless insurance and/or deferred payment arrangements are made.

We accept cash, credit cards (Visa, Mastercard, Discover)

We offer insurance billing with the following conditions:

* All co-pays are due at the time of the visit
* All balances after insurance are due upon receipt of first billing

As a service to our patients we will gladly submit insurance claims to the insurance companies we participate with such as Medicare, Blue shield of Maryland and DC, Aetna, Cigna, BCBS

We will only bill an insurance company three times for the same charge. After that, it will be the responsibility of the patient to pay the entire balance and then obtain reimbursement from their insurance company.

***Obtaining referral authorization is the responsibility of the patient****.* If a claim is denied because the patient does not bring in a referral, the patient is responsible of the entire balance.

If, after the fourth billing, we have not received any response from the patient, the account may and probably will be turned over to a collection agency without further notice.

We charge $25 for any office visits/follow up appointments missed, without notice.

If you need to cancel/reschedule your Nuclear Stress Test Appointment, you need to alert the office by 12pm the day before.

For any missed Nuclear Stress Test appointments without proper cancellation notice will result in a strictly enforced $200 charge to recoup the cost of the radionuclide dose.

**I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES AND AGREE TO FOLLOW THEIR PROVISIONS**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of the HIPAA notice of privacy practices today.**

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

I hereby give my consent for SRIDHAR CHATRATHI, MD 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 SRIDHAR CHATRATHI, MD describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. It reserves the right to revise its Notice of Privacy Practices may be obtained by forwarding a written request to ATTN: OFFICE MANAGER, 7500 HANOVER PKWY #105, Greenbelt, MD 20770.

With this consent, SRIDHAR CHATRATHI, MD may call my home or other alternative location and leave a message on voicemail 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, SRIDHAR CHATRATHI, MD 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, SRIDHAR CHATRATHI, MD may email to my home or other alternative location any items that’s assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that SRIDHAR CHATRATHI, MD 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, SRIDHAR CHATRATHI, MD 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, SRIDHAR CHATRATHI, MD may decline to provide treatment to me.

We have chosen to participate in the Chesapeake Regional Information System for our patients, Inc. (Crisp)

Crisp is a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable all access to your health information available through Crisp by calling 1-877-952-7477 or go online at [www.crisphealth.org](http://www.crisphealth.org)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or legal guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name**