KANTHI RAJU, D.O., P.A.
2150 LAKESIDE BOULEVARD, SUITE 225E
RICHARDSON, TX 75020
Ph: 972-907-5230 Fax: 972-907-5231

REGISTRATION & CONSENTS FORM

Patient Name:_____ Date of Birth:_____
Last First Middle

Sex: □M □F SSN: _____ Marital Status: □ Sin □ Mar □ Div □Sep □ Wid

Parent/Guardian Name: _____
Last First Middle

Address: _____
Street Apt. City State Zip Code

Mailing Address(if different from above): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred Contact Phone: _____

INSURANCE INFORMATION (please present your insurance card to receptionist)

Subscriber's Name: _____Date of Birth: _____

Subscriber's Relationship to Patient: □ self □ spouse □ child □ other_____

Primary Insurance Company: _____

Subscriber's ID # _____Group # _____

Primary Insurance Company Phone: _____

Primary Insurance Company Address for Claims: _____

Subscriber's Employer: _____

Subscriber's Employer Address: _____

Subscriber's Employer Phone: _____

Secondary Insurance Company: _____

Subscriber's Name: _____Date of Birth: _____

Subscriber's ID#_____ Group # _____

Patient's Signature: _____Date: _____

Parent/ Guardian Signature: _____Date: _____

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CONSENT FOR TREATMENT/ SERVICES

I understand that Dr. Raju originates and maintains health records including my history, symptoms, evaluations, test results, diagnosis, treatment, psychotherapy notes, and plans for future treatment; and, that this information is utilized to plan my treatment, bill for services, communicate with other healthcare providers, assess quality, and review competence of healthcare professionals. I authorize and request Dr. Raju to carry out diagnostic procedures, psychological evaluations, psychotherapy, and/or psychopharmacological treatment, which may be required at this time or during the course of my treatment. I understand the purpose and risks of these treatment recommendations will be explained to me upon request and subject to my agreement. I understand that there are no guarantees regarding the outcome of my treatment.

_____ _____
Patient/ Parent/ Guardian/ Conservator Signature Date

CONSENT FOR TREATMENT OF CHILD OR DEPENDENT

I am the legal guardian or representative of the patient and on the patient's behalf, legally authorize the practitioner to deliver mental health services to the patient. I understand that all policies in these consents apply to the patient I represent.

_____
Patient Name

_____ _____
Parent/Guardian/Conservator Signature Date

AUTHORIZATION TO RELEASE INFORMATION TO HEALTH PROVIDERS

I authorize release of information to my primary care physician, other health providers, institutions, and referral sources for the purpose of my diagnosis, treatment, consultation, and professional communications:

_____ _____
Primary Care Physician Name/ Phone Therapist Name/ Phone

_____ _____
Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION TO OTHER PERSONS

Health information that Dr. Raju collects and/or receives about me may be disclosed to the following persons:

_____ _____
Name of Person/Relation/Organization & Phone Name of Person/Relation/Organization & Phone

_____ _____
Name of Person/Relation/Organization & Phone Name of Person/Relation/Organization & Phone

_____ I do not authorize the following information to be disclosed to any parties except me as the patient:

_____
Information Specified Against Disclosure

MESSAGES

Dr. Raju and her staff may leave messages regarding appointments, prescriptions, and/or treatment at the following numbers:

_____ _____
Home Phone Work Phone

_____ _____
Cellular Phone Other Phone

PRESCRIPTIONS (IF APPLICABLE)

Prescriptions are given by Dr. Raju to the patient at the time of their appointment. If you need to request a refill before your next appointment, please have your pharmacy fax a refill request to our office, so that it may be approved by Dr. Raju within 48 hours. Please request stimulant refills by fax or email. Stimulant prescriptions must be picked up at the office by the patient or authorized person and filled within 21 days, and are billed $10 to the patient. Rewrites are $15.

_____
Name of Person Authorized to Pick Up Prescriptions for the Patient

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CONSENT FOR RELEASE OF INFORMATION UPON INSURANCE ASSIGNMENT

I authorize Dr. Raju and her contracted billing company "Glenwood Systems" to assignment of my insurance benefits for charges for treatment rendered to me. Dr. Raju has agreed to accept assignment of my insurance benefits. I agree to sign any and all forms necessary for the submission of a claim for payment of benefits to my practitioner by my insurance company. I hereby consent and authorize Dr. Raju to provide my insurance company with any and all information requested in connection with its review and consideration of the claim for payment of benefits. I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information requested by my insurance company, and I hereby release all parties from any and all liability arising from release of information and records requested. I understand that Dr. Raju files insurance claims as a courtesy and in no way releases the patient from responsibility of his/her bill. I agree to accept responsibility for my bill in the event that insurance denies or partially pays for the claim.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

ACKNOWLEDGEMENT OF POLICES AND PROCEDURES REGARDING TREATMENT FOR KANTHI RAJU, D.O., P.A.

Please sign below to indicate that you have received a copy of *Policies and Procedures Regarding Treatment by Kanthi Raju, D.O., P.A.* and that you have understood and acknowledged all of the consents, policies, terms, and information contained throughout.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

ACKNOWDGEMENT OF NOTICE OF PRIVACY POLICIES AND PRACTICES FOR KANTHI RAJU, D.O., P.A.

Please sign below to indicate that you have received a copy of *Notice of Privacy Policies and Practices for Kanthi Raju, D.O., P.A.*

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

EXPIRATION OF AUTHORIZATION

Your consents and authorizations will be effective from the date of your signature until you revoke or terminate such consent by submitting a written notice to Kanthi Raju, D.O., P.A. or your treatment has been terminated by you or Dr. Raju.

Please keep the pages of this packet which include
***Policies and Procedures Regarding Treatment for Kanthi Raju, D.O., P.A.* and**
Notice of Privacy Policies and Practices for Kanthi Raju, D.O., P.A.