Kuldeep Singh, MD
Singh Medical Practice
4104 W 15th St., Ste 102, Plano, TX 75093
Phone 972-943-1916 Fax 972-943-1917

WELCOME TO OUR OFFICE Please provide us with the following information
Name: ______________________________ Date of Birth: ______________

ALL medical conditions for which you have been treated (as many as you can think of):

__________ __________ __________ __________
__________ __________ __________ __________
__________ __________ __________ __________

ALL Drug allergies that you have: __________ __________ __________
__________ __________ __________ __________

List ALL medications/OTC supplements/Oral health agents you take:

NAME	STRENGTH	HOW MANY TIMES TAKEN A DAY

(CONTINUE ON BACK IF NECESSARY)

SURGERIES: ______________ ______________ ______________
__________ __________ __________ __________
(CONTINUE ON BACK IF NECESSARY)

Have you had a Colonoscopy? Y or N (circle) date: __________ normal/abnormal (circle)
When did you last have blood work completed? Date: __________

FAMILY HISTORY: List health conditions (cancer, heart problems, diabetes, depression)
Mother: ____________________ Father: ____________________
Sisters: ____________________ Brothers: ____________________

SOCIAL HISTORY: Marital status: married single divorced (circle)
Children: Name and year born - ______________________________
Hometown (where you grew up): __________ Military __________ no roots (circle)
Hobbies/leisure activities: ______________________________
Employed: Y N or Retired (circle) What is/was your occupation? __________
Smoker: Y or N (circle) quit date __________ Alcohol: never rarely social daily (circle)

GYNECOLOGIC: Date of last mammogram: __________ Normal? Y or N (circle)
Date of last pap smear date: __________ History of abnormal pap? Y or N (circle)
Date or last bone density study: __________
Birth Control: none IUD pills tubal condoms patch vasectomy other (circle)

Other Doctors/providers that you see: Eye: __________ OB/GYN: __________
Heart: __________ Skin: __________ Orthoped: __________ GI: __________

Do you have an advanced directive: Y or N (circle) Name of your POA: __________

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Patient Registration Form

Patient Information

Patient Name: ______________________ Sex: _____M _____F
Race: ____________ Ethnicity: ____________ Preferred Language: ____________
Social Security #: ______________________ Date of Birth: ____________
Address: ______________________ Apt: ____________
City, State: ______________________ Zip Code: ____________
Home Telephone (Primary): ____________ Work: ____________ Cell: ____________
Email address: ______________________
Employer: ______________________
Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed _____ Separated
Spouse's Name: ______________________
Spouse's Employer: ____________ Employer Phone #: ____________

If patient is a minor:

Guardian Name: ____________ Relationship: ____________
Date of Birth: ____________ Social Security #: ____________
Address: ____________ Contact #: ____________
____________ Email: ____________
Who may we thank for referring you? ______________________

What Pharmacy do you use? ____________ Address: ____________
Phone Number: ____________ Fax Number: ____________

Emergency Contact:

Name: ____________ Relationship: ____________
Address: ____________ Apt: ____________
City, State: ____________ Zip Code: ____________
Home Phone: ____________ Cell: ____________ Work: ____________

Insurance:

Primary Insurance Co. Name: ______________________
Member, Policy, or ID Number: ____________ Group #: ____________
Claims Address: ____________ City, State: ____________
Policy Holder's Name: ____________ Date of Birth: ____________
Address and Phone: ______________________
Secondary Insurance Co. Name: ______________________
Member, Policy, or ID Number: ____________ Group #: ____________

RELEASE (Please Read Carefully)

I authorize the release of any medical information necessary to process this claim and any other future claims. I also authorize payment of medical benefits to Singh Medical Practice, PLLC. In the event that my insurance company does not cover services, I will be responsible for any unpaid balances, subject to any interest or late fees, or collection fees.

Signature: ______________________ Date: ____________
Relationship to Patient: (if other than patient) ______________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________, AM AWARE OF SINGH MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES.

I AM ALSO AWARE THAT I MAY REQUEST A COPY OF THE NOTICY OF PRIVACY PRACTICES.

______________________________ ____________________

SIGNATURE DATE

(IF COPY REQUESTED – PLEASE SIGN BELOW)

I, ______________________________, HAVE RECEIVED A COPY OF SINGH MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES.

______________________________ ____________________

SIGNATURE DATE

HIPPA Notice of Privacy Practices

Singh Medical Practice, PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, or mental health condition and related health care services.

Uses and Disclosures or Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the physician's practice, and any other use required by law.

Payment: Your protected health information will be used as needed to obtain payment for your health care services, including from your family members or friends. For example: obtaining approval for a medical procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information:

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information:

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us, you may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became affected on **March 01, 2010.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 972-943-1916.

I, ______________________________, have received a copy of the above Notice of Privacy Practices from this office and give my permission to all of the above.

____ Date: ____________________
Please Print Name

____ Date: ____________________
Signature

You may refuse to sign this acknowledgement
If refusing: ______________________________________ Date: ____________________
Signature

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information: form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician about questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Singh Medical Practice, PLLC

Missed Appointment and Cancellation Policy

At Singh Medical Practice, your time is valued. Dr. Singh strives to see his patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We will collect a $50.00 fee to ensure that Dr. Singh can continue to see patients. Please take note that the cancellation and missed appointment fee will not be covered by your insurance. The patient is solely responsible for this charge. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

Please refer to the guidelines below to learn more about our Missed/Cancellation policy:

- It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us maintain your records.
- Effective January 1, 2014, each missed appointment will be flagged and you will receive a notice that you have missed your appointment. In addition, your account will be assessed a $50.00 missed appointment/cancellation. Please see note that the fee will not be billed to your insurance.
- Accounts that accumulate three missed appointments fees may be dismissed from the practice.
- Any cancellation not made at least 48 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.
- If you arrive 20 minutes late for your scheduled appointment, without prior notification to our office, this may also be considered a "missed appointment." Please remember that communicating with our office is critical to us providing you with quality health care.
- We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible. We will waive the cancellation for this appointment as long as you do not have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those slots.

  We realize there are times that you may arrive for a scheduled appointment time and are not able to been seem promptly at your appointed time. Please know that we will go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know the status of our schedule.

Name of Patient____

Signature of Patient____________________________ Date__________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Date: ____________________

1. Patient Name: ______________________________

   Date of birth: ______________________________

   Phone: ______________________________

Persons/organization(s) providing records:
(Complete address/phone #)

____
____
____
____

Person/organization(s) receiving record:

____
____
____
____

Covering all periods of care from: _________________________ to _________________________

2. Information to be released:

   _____ Copy of complete medical records

   _____ History and Physical

   _____ EKG

   _____ X-rays

   _____ Echocardiogram

   _____ Lab Work

   _____ Other: ____________________

3. Purpose of disclosure: ______________ To send to insurance company

   ______________ To send to new general physician

   ______________ To transfer care to new cardiologist

4. I understand this consent can be REVOKED at any time except to the extent that disclosure make in good faith has already occurred in reliance on this consent.

5. Specification of the date, event of condition upon which this consent expires: ______________

   ____

6. The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorization herein.

Signed: ____________________________________ Date: ____________________
Patient or representative

____