Bhuvana Balasekaran, MD
1301 W Wall St Ste C
Midland, TX 79701

Date:_____

Patient Information:

Name:_____
(First) (MI) (Last)
Address:_____**City**_____**State**_____**Zip**_____
_
Home Phone:_____**Business Phone:**_____**Cellphone:**_____
Date of Birth:_____Age:_____ Female_____ Male_____ S___M___W___ D___Sep____
Employer:_____
Drivers License#_____Social Security #_____
Spouse/Parent/Guardian name:_____
Referred by:_____

Person responsible for payment:

Name:_____DOB:_____
Address:_____
Employer:_____SS#_____
Home Phone:_____Business Phone:_____Cell Phone:_____

Insurance:

Primary Insurance name:_____
Mailing address:_____
Policy holder name:_____Relationship to patient:_____
Member ID#_____Group#_____

Person to contact in case of emergency:

Name:_____Relationship:_____
Home phone:_____Business phone:_____Cell Phone:_____

Payment Policy: *PAYMENT IS REQUIRED AT TIME OF SERVICE*

Your receipt for each visit will contain all the information needed to process an insurance claim. Please remember that insurance is a method of reimbursing you for fees paid to the doctor and is not a substitute for payment.
I hereby assign to Bhuvana Balasekaran,MD all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any and all amounts not covered by insurance. There is a fee of 1.00 per page for any and all copies.
The above registration information is correct to the best of my knowledge, and I understand and accept the above payment policies.

HIPAA Policies:

I hereby acknowledge that I have received/reviewed the notice of privacy practices for Dr Bhuvana Balasekaran, MD which explains how my medical information will be used and disclosed. I understand that a copy of these privacy practices will be made available to me, at my request.
I hereby authorize Dr Bhuvana Balasekaran, MD to furnish information to my insurance carrier, and retrieve any and all information from any pharmacies regarding or concerning all of my or my dependents medical care.

Controlled Drug Agreement:

If I have been prescribed a controlled drug, I have been given the triplicate prescription agreement, acknowledge that I understand and will abide by this policy.

_____Date:_____
(Patient/guardian signature)