REGISTRATION FORM

Dr. Lawrence Epstein & Dr. Suneetha Maddineni

Last Name ________________________ First Name _________________________ Middle __________ Gender___

Address_______________________________ City___________________________ State_______ Zip_________

Home Phone__________________ Cell Phone________________________ Work Phone____________________

Email Address______________________________ I agree to communicate with my provider's billing dept. Yes /No

Date of Birth__________________ Social Security No_______________ Marital Status_____ M____ D_____ S____

Race ________________ Ethnicity: Hispanic or Latino Neither Unknown Decline Primary Language ___________

Patient's Employer_____________________ Referred By ____________________Previous Physician__________

Pharmacy_____________________ Phone Number_____________________ Spouse____________________

INSURANCE INFORMATION

We will submit all claims to appropriate insurance companies. We will file claims only for Services in connection with hospitalization for all carriers. We will require a copy of your insurance card(s). Should we not be contracted with your insurance carrier. It is the policy of our office that office visits and tests are to be paid at the time of service.

Primary Insurance Name___________________________________ Type: HMO PPO POS EPO Medicare

ID #_______________ Group #______________

Subscriber ____________________________ Relationship to Patient ______________

Secondary Insurance Name ________________________________ Type: HMO PPO POS EPO Medicare

ID #______________ Group #_______________

Subscriber _____________________________ Relationship to Patient _____________

PERSON RESPONSIBLE FOR PAYMENT

Name____ Relationship______________________________

Phone No.____ Address_______________________________________

City_____________________________ State____________ Zip Code_________________________

Work Phone________________________ Social Security No.____________________________

I, ____, accept responsibility for payment of services rendered.

(Patient/Guardian Signature)

IN CASE OF EMERGENCY, PLEASE CONTACT

Name______________________________________ Relationship_______________________________________

Address____________________________________ City_______________ State___________ Zip Code__________

Primary Phone # Home/Cell/Work _______________________ Secondary Phone # Home/Cell/Work________________

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize payment of medical benefits to Dr. Lawrence A. Epstein, M.D/ Dr. Suneetha Maddineni M.D. for the charges covered by my insurance, if any. I will be responsible for all charges not covered by this assignment. I authorize release of any medical information, including photocopies of medical records or insurance information, to my insurance carrier(s) or administrator(s) for payment purposes, utilization requests, or coordination of benefits. These authorizations shall remain valid as long as I am a patient of Dr. Lawrence A. Epstein, M.D./Dr. Suneetha Maddineni M.D. I understand and accept that any cancellation made within 24 hours of my scheduled appointment time, or any missed appointment may be subjected to a service charge. I understand that I may request and receive a copy of this document. A photocopy shall be considered valid.

Signature____ Date______________________________

INFORMATION ABOUT YOU PHYSICAL EXAMINATION

Dr. Lawrence Epstein & Dr. Suneetha Maddineni

You are scheduled for physical examination at the offices of Dr. Epstein/Dr. Maddineni, and we would like to provide you with information regarding your services prior to your appointment.
The National Correct Coding Initiative (CCI) establishes and publishes the coding regulations used by Medicare and insurance carriers with which Dr. Epstein & Dr. Maddineni contract. CCI has instituted rules that may affect how you are charged for the services you receive. Physicians must specify the type of services they provide to a patient-whether preventive care or problem-related care-with specific procedures codes. Health insurers look at these procedure codes when determining which services they will cover.

As a result of these federal guidelines and insurance practices, your physician may charge for both preventive examination and a problem-related office visit if you are treated for a specific health problem during your visit. The care you receive will not change and your physician remains committed to providing the highest-quality care.

FREQUENTLY ASKED QUESTIONS:

What is the difference between a physical examination and an office visit?

- A physical exam is a **preventive** health maintenance exam during which your physician takes your relevant medical and family history; asks pertinent screening questions; and performs or orders appropriate screening tests based on your age, sex and medical risks to evaluate your overall health.
- An office visit is a **problem-related** visit that addresses a specific health problem through discussion, examination, diagnosis and/or testing. Treatment is prescribed as necessary.

Why would my physician charge for two services at one appointment?

CCI specifies that your physician must code and document separately for preventive care, such as a physical exam, and a problem-related care, such as a sprained ankle or hypertension. Additionally, health insurers do not consider preventive care and problem-related treatment the same service and pay for them separately. Therefore, if you receive treatment for a specific health problem during your physical exam, your physician is required to document and charge for these services separately.

- Charging for two services is defined as a correct physician billing practice by CCI, which was established by the Federal Department of Health and Human Services (HHS) and is standard practice in medicine.
- Providing both services during one appointment uses your time and your physician's time effectively and generally means the problem-related visit may be charged at a lower fee than if it were provided at a separate visit.
- Your physician is required to document all services provided to you, ensuring your medical record is complete and reflects accurate information about your health.

Thank you for trusting us with your care.
Dr. Epstein and Dr. Maddineni

Sign Name______________________________

Print Name_____________________________

Date___________________________________

FINANCIAL POLICIES

Dr. Lawrence Epstein & Dr. Suneetha Maddineni

PATIENT INFORMATION: You will be asked to fill out a patient information form at your initial visit and each year thereafter. Please inform us of any changes of information such as insurance, address, telephone number, and employer.

INSURANCE: Our office contracts with many insurance companies and plans. Your insurance company provides you with proof of insurance, which must be presented for all services provided. If proof of insurance is not presented, your account will be considered a cash account with full payment expected at time of service.
If we are contracted as preferred providers with your health plan, we will bill your insurance company directly. If we are not contracted providers with your insurance company, we expect payment in full at the time of service. We will be happy to provide you with the information you need to bill your insurance company for any eligible reimbursement.
Your individual insurance plan is an agreement between you and your insurance company. It is necessary for you to know the specific details of your own plan. It is especially important for you to notify us if there are restrictions regarding referrals for services by outside facilities or providers. You may be responsible for charges from those outside providers if they are not preferred providers with your insurance company or you have not received the proper authorization prior to receiving services.

CO-PAYS: As required by your insurance company, your co-payment is due at the time of each visit. For your convenience, we accept cash, check, and credit. There will be a $20 administrative fee for unpaid co-pays.

Missed Appointments: Our missed or cancelled appointment in less than 24 hours notice is $25.00 for 15 minutes appointment and $75 for 30 minutes and greater appointment.

RETURNED CHECKS: A fee of $25.00 is charged for a returned check.

REPORT COMPLETION/FILING: A minimum of $25.00 will be charged for forms or letters which must be completed by a provider. This fee must be paid before the forms can be released or mailed. This pertains to forms such as disability forms, FMLA forms, DMV forms, college health reports, or letters written.

RECORDS COPYING: There will be a charge for copying of medical records.

I have read, understand, and agree to this Financial Policy.I verify that I am fully responsible for the fees and medical services provided by Dr. Epstein and Dr. Maddineni. In the event that medical services provided by Dr. Epstein and Dr. Maddineni are deemed ineligible by my insurance, I am responsible for the full cost of the services.

Sign Name ________________________________

Print Name ________________________________

Date _____________________________________

MEDICAL HISTORY PATIENT QUESTIONNAIRE

PAST MEDICAL HISTORY PLEASE CHECK ALL CONDITIONS THAT APPLY:

▯ AIDS/HIV
▯ ANEMIA
▯ ANXIETY
▯ ARTHRITIS
▯ ASTHMA
▯ ATRIAL FIBRILLATION
▯ BLOOD PRESSURE ▯HIGH ▯LOW
▯ BLOOD CLOTS
▯ CANCER __________
▯ CORONARY ARTERY / HEART DISEASE
▯ CONGESTIVE HEART FAILURE YEAR:
▯ DEMENTIA
▯ DEPRESSION
▯ DIABETES ▯ TYPE 1 ▯ TYPE 2
▯ EMPHYSEMA
▯ HEADACHES/MIGRAINES
▯ HEPATITIS ▯A ▯B ▯C
▯ HEARTBURN
▯ HEART DISEASE / MURMUR
▯ LUNG PROBLEMS ____________________
▯ HIGH CHOLESTEROL
▯ KIDNEY DISEASE / PROBLEMS
▯ LIVER DISEASE / PROBLEMS
▯ OSTEOPOROSIS
▯ PERIPHERAL ARTERY DISEASE
▯ TUBERCULOSIS ▯ACTIVE ▯ LATENT
▯ PROSTATE PROBLEM
▯ SEIZURES
▯ SEXUALLY TRANSMITTED DISEASE
▯ SHORTNESS OF BREATH
▯ SINUS PROBLEMS
▯ SLEEP APNEA
▯ STROKE YEAR____________
▯ THYROID DISEASE
▯ ULCERS OF THE STOMACH
▯ OTHER _____________________________

Please describe any current or past medical treatment or problems not listed above, include year or duration.
____

Have you been hospitalized? ▯ NO ▯ YES If yes, what for? _______________________________

SURGERY HISTORY PLEASE CHECK ALL THAT APPLY:

▯ APPENDECTOMY YEAR _________
▯ CARDIAC ANGIOPLASTY, STENT OR BYPASS YEAR _________
▯ CESAREAN SECTION YEAR _________
▯ GALLBLADDER YEAR _________
▯ HERNIA REPAIR YEAR ________
▯ HYSTERECTOMY YEAR________
▯ PROSTATE SURGERY YEAR ________
▯ TONSILLECTOMY YEAR________

MEDICATIONS

Name	Dose & Directions	Reason

ALLERGIES PLEASE CHECK ALL THAT APPLY (AND LIST REACTION)

▯ ACETAMINOPHEN LIKE TYLENOL ____________
▯ AMOXICILLIN ___________________________
▯ ASPIRIN ________________________________
▯ FOOD _________________________________
▯ IBUPROFEN LIKE ADVIL OR MOTRIN _______________________________
▯ LATEX ____________________________
▯ PENICILLIN ____________________________
▯ SULFA ____________________________
▯ OTHER ____

FAMILY HEALTH HISTORY

FAMILY MEMBER	AGE (OR AGE AT DEATH)	MEDICAL CONDITION/ILLNESS
MOTHER		
FATHER		
SIBLING		
SIBLING		
GRANDPARENT		
GRANDPARENT		
GRANDPARENT		
GRANDPARENT		
OTHER		
OTHER		
OTHER		

SOCIAL HISTORY

SMOKING ▫ NEVER ▫ PREVIOUS ▫ CURRENT; Packs per day _______ Since _________

▫ HOOKAH ▫ MARIJUANA ▫ TOBACCO ▫ VAPE

ALCOHOL ▫ NEVER ▫ OCCASIONAL ▫ OFTEN; Drinks per week ______ Since _________

DRUG USE ▫ NO ▫ YES If yes, this will be discussed with the Physician

IMMUNIZATIONS

NAME	DATE ADMIN
FLU	
PNEUMO	
TDAP	
ZOSTER	