REGISTRATION
(PLEASE PRINT)

Bishnu P. Verma, M.D., P.A.
1555 Saxon Boulevard, Suite 601
Deltona, FL 32725
Phone: (386) 860-2600

Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have Insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to *Dr. Bishnu P. Verma /Bishnu P. Verma, MD, PA* all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Bishnu P. Verma, M.D., P.A.

Internal Medicine | **Diplomate ABIM in Internal Medicine**

American College of Physicians
Internal Medicine/Doctors for Adults

HEALTH HISTORY (Confidential)

Name: _____ Today's Date: ____/____/____

Age: _____ Birthdate: _____ What is the Reason for this Visit _____

Allergies to Medicines or Substances _____

MEDICATIONS: (List medications that you are currently taking)

CONDITIONS Check (✓) conditions you have, or have had in the past.

☐ Alcoholism	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Cancer	☐ Cataracts	☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Gout
☐ Heart Disease	☐ Hepatitis	☐ High Cholesterol	☐ High Blood Pressure	☐ Kidney Disease	☐ Live Disease
☐ Migraine Headaches	☐ Pacemaker	☐ Pneumonia	☐ Prostate Problem	☐ Psychiatric Care	☐ Stroke
☐ Suicide Attempt	☐ Thyroid Problems	☐ Ulcers	☐ Vaginal Infections	☐ Venereal Disease	☐ Other _____

DATE OF:
Last Menstrual Period_____ Last Pap Smear_____ Last Mammogram_____

FAMILY HISTORY: Fill in Health information about Your Family. Check (✓) if Your Blood Relatives had any of the following:

Disease	Relationship to You
Cancer	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	

HOSPITALIZATIONS / SURGICAL HISTORY

Year	Reason for Hospitalization

IMMUNIZATIONS

☐ Influenza Vaccine Date_____ ☐ Pneumonia Vaccine Date_____

☐ Tetanus Booster Date_____

Have you ever had a Blood Transfusion? ☐ Yes ☐ No

Do you have an Advance Directive (Living Will) for your Medical Care? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge.

_____ _____
Signature Date

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Bishnu P. Verma, M.D., P.A.

Internal Medicine

Member of American Medical Association
American Society of Internal Medicine
Florida Society of Internal Medicine

Name _____

AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT

I, THE UNDERSIGNED PATIENT, PARENT, OR LEGAL GUARDIAN, KNOWNING THAT I AM/THE PATIENT IS SUFFERING FROM A CONDITION REQUIRING MEDICAL CARE, DO HEREBY CONSENT TO SUCH MEDICAL CARE ENCOMPASSING ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT BY BISHNU P. VERMA, M.D. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT OR EXAMINATION.

PATIENT SIGNATURE_____

PATIENT REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____

DATE_____

I ACKNOWLEGE THAT I ☐ **DO** ☐ **DO NOT** HAVE MEDICARE COVERAGE. (IF I DO HAVE
(circle one)

COVERAGE, THEN I WILL PROVIDE A COPY OF MY MEDICARE CARE). **INITIALS**_____

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Financial Policy

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assurance and understanding about our payment policy.

Payments and Co-payments Are Due At The Time Services Are Rendered unless prior arrangements have been made by our staff. We accept cash, check and credit card. Returned checks are subject to a service fee of $25.00 or 5% of the face value of the check, whichever is greater and you will lose your privilege to write checks in our office.

MEDICARE: Since we are a Medicare provider we will file your Medicare claims. You are responsible for the Medicare deductible per calendar year and the 20% of allowable charges.

SUPPLEMENTAL INSURANCE POLICY: We would be happy to file your supplemental insurance claims, only if the correct information is given at the time of your appointment. If there is a discrepancy after filing claim, it is patient's responsibility to contact the insurance company. We will send you a bill and payment for services are due at this time. As courtesy we file your insurance claims to your insurance carrier, all charges are your responsibility.

BC/BS INSURANCE POLICY: Payment is due at the time services are rendered. Most of the BC/BS insurance company pays directly to patients. We will be happy to help you process your insurance claim-form for your reimbursement.

WORKER'S COMPENSATION OR AUTOMOBILE CLAIMS: You are required to bring the appropriate information for filing your claim. If at the time of service this information is not available, the bill will be your responsibility and payment will be due at the time services are rendered. In the event your claim for this condition or illness is denied by Worker's Compensation Board or Automobile insurance as not being related to your employment or accident, you agree to pay the usual and customary fees for service rendered to you in this case.

HMO POLICY: If we are a participating provider with your HMO plan, we file your insurance claim. You are responsible for all applicable co-payments and/or deductibles.

FAIL TO SHOW: Patients who do not cancel appointments may be charged accordingly.

FINANCIAL AGREEMENT: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. ***ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.*** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account. If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: _____ **Date:** _____

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Request for Restrictions of PHI

I, _____, understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other healthcare operations.

You may contact me by e-mail, mail at home and/or at the following address:

E-mail: _____

Address: _____

_____

You may contact me or leave me a massage at home and at the following telephone number:

#1. _____

#2. _____

You may discuss any portion of my medical record with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

(If you are 18 years old, must be signed by parent or guardian)

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Bishnu P Verma MD, PA's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Bishnu P Verma MD, PA may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Bishnu P Verma MD, PA's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Bishnu P Verma MD, PA's *Notice of Privacy Practices.*

____
Printed Patient Name

______________________________ ______________________________
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

______________________________ ______________________________
Printed Patient Personal Representative Name Relationship to Patient

______________________________ ______________________________
Patient Personal Representative Signature Date

♦♦♦

For Bishnu P Verma MD, PA Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Bishnu P Verma MD, PA made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reason documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other ______________________________

____
Employee Name (Printed)

______________________________ ______________________________
Employee Signature Date

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CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to this practice and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the below address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

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Agreement to Share Medical Data

Given current health care challenges and evolving software and technology changes, we need your consent to share your personal health information with:

- Consulting Physicians
- Primary care Providers
- Pharmacies
- Laboratories
- Radiologists
- Hospitals
- Clinics
- Accountable Care Organizations (ACO)
- Insurance Companies
- Any regulatory request

I give my consent to the above.

Signature: _____

Patient Name: _____

Guardian or Power of Attorney: _____

Date: _____

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