RAO V.SUNKAVALLY, M.D., F.A.C.S. **PATIENT REGISTRATION FORM**
UROLOGY

***PLEASE FILL OUT COMPLETELY AND SIGN AT THE 'X'** **TODAY'S DATE:**_____

Patient Name:_____ **Birthdate:**_____ **Age:**_____

Address:_____ **Sex:**_____ **Marital Status:**_____

City:_____ **Zip Code:**_____ **Home Phone:**_____

Social Security Number:_____ **Work Phone:**_____

Employer/School Name:_____ **Referring Doctor:**_____

Employer address:_____ **Patient E-mail :**_____

Spouse's Name:_____ **Spouse's SS Num:**_____

Spouse's Employer Name:_____ **Spouse's Work Phone:**_____

Spouse's Employer Address:_____ **Contact Person:**_____

Person Responsible for Bill:_____ **His Home Phone:**_____

Address of the Person:_____ **His Work Phone:**_____

INSURANCE COVERAGE #1

Insurance Company Name:_____ **Phone Number:**_____

Address:_____ **Group #:**_____

ID#:_____**Plan #:**_____ **Medical Grp Name:**_____

Cardholder's Name:_____**DOB:**_____ **Relationship to Patient:**_____

Effective Date:_____ **Filing Order:**_____ **Authorization #:**_____

INSURANCE COVERAGE #2

Insurance Company Name:_____ **Phone Number:**_____

Address:_____ **Group #:**_____

ID#:_____**Plan #:**_____ **Medical Grp Name:**_____

Cardholder's Name:_____**DOB:**_____ **Relationship to Patient:**_____

Effective Date:_____ **Filing Order:**_____ **Authorization #:**_____

WORKMEN'S COMP INS NAME:_____ **Phone Number:**_____

Address:_____ **Date of Injury:**_____

Agent's Name:_____ **Claim Number:**_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I, the undersigned, has insurance coverage as stated above and authorize you to release any medical information necessary to process the claims. I further assign directly to Rao V.Sunkavally,M.D.,F.A.C.S., all surgical and/or medical benefits, if any otherwise payable to me for the services rendered. I further agree to pay all charges not covered or not paid by my Insurance Company. I understand that insurance problems are not considered an acceptable reason for lack of payment of my account.

X_____ X_____
Signature of Patient or Responsible Person Date Signed

X_____
Print name of person signing this form

Please continue on the back page

***PLEASE FILL OUT COMPLETELY AND SIGN AND DATE AT THE 'X'**

PRESCRIPTION HISTORY CONSENT:

I agree that Dr.Rao V.Sunkavally, M.D.,F.A.C.S. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

X_____ X_____

Signature of Patient or Responsible Person Date signed

PRIVACY NOTICE:

In accordance with the Health Insurance Portability and Accountability Act, patients of Rao V.Sunkavally, M.D.,F.A.C.S are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. Rao V.Sunkavally, M.D.,F.A.C.S will strive to ensure that patient information is used for purposes authorized by the patient and as otherwise required by law. Upon request, we can provide you with a complete copy of our Privacy Policies. Additionally, patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice.

X_____ X_____

Signature of Patient or Responsible Person Date signed

CONSENT TO TREATMENT:

I consent to the treatment by Dr. Rao V.Sunkavally, M.D.,F.A.C.S. I agree that I will be responsible for keeping my appointments for follow-up visits, for undergoing diagnostic procedures and for following the treatment instructions that will be given by Dr.Rao V.Sunkavally,M.D.,F.A.C.S. I will also be responsible for seeing other specialists as and when recommended by Dr.Rao V.Sunkavally,M.D.,F.A.C.S. I understand that in the event of me not following the above outlined responsibilites, Dr.Rao V.Sunkavally, M.D.,F.A.C.S will not be held responsible for any adverse outcome of my condition.

I have been informed by this office that the products used in the course of my treatment (such as resuscitation products, catheters and collection devices) contain a chemical known to the State of California to cause cancer. (Prop.65)

X_____ X_____

Signature of Patient or Responsible Person. Date signed.

COMPLETION OF FORMS:

I understand that this office charges $25.00 for filling out private disability forms or other forms, or for preparing letters for whatever purpose. I also understand that this charge is for each form or letter that this office is requested to fill out. I further understand that this office requires 7 days for completion of my request.

X_____

X_____

Signature of Patient or Responsible Person. Date signed.

FINANCIAL OBLIGATIONS:

In return for the services to be rendered, I hereby agree and individually obligate myself to pay the account of this Office. However, if I am eligible to receive benefits under a healthcare service plan with which this Office has contracted, I shall not be obligated to pay for services covered under the plan which are paid pursuant to the contract. All amounts past due for more than sixty (60) days are subject to a one and one half (1½) percent interest charge. Should my account be placed for Collection, I agree to pay all Collection Costs including Attorney's fees and Court Costs.

If my CHECK OR OTHER PAYMENT IS RETURNED UNPAID by my bank, I agree to pay a RETURNED PAYMENT FEE OF: Amount $25.00 per check.

I have received this Disclosure Statement prior to any service or Collection charges made to my account.

X_____ X_____

Signature of Patient or Responsible Person. Date Signed.

***PLEASE FILL OUT COMPLETELY AND SIGN AND DATE AT THE 'X'**