

## WELCOME

*I am glad you are part of our practice. Your health is our priority.*

*Let me introduce myself. I have been in practice for over ten years. I completed my family medicine residency at Baylor College of Medicine; and worked in a rural community in Texas thereafter where my job responsibility encompassed outpatients, in hospital patients and emergency room coverage.*

*These experiences have helped me tremendously to better realize and understand the healthcare needs of a community.*

*Let me share with you a few tips to improve the efficiency of our services and maximize the benefit of your visit to our office.*

*Please ensure that you arrive at least 10 to 15 minutes earlier especially if you are a new patient so your registration can be a smooth rather than a hurried process.*

*Please keep your ID and insurance information handy.*

*Make sure you let us know any change in address, phone number or insurance information when you sign in so we can update your records and any correspondence addressed to you not be missed.*

*Each office visit typically lasts 15minutes; however if you think you need more time or if you need a procedure scheduled with the physician please let us know when you make your appointment so we can take care of your needs.*

*For an annual physical please do not eat or drink anything (except water) for at least 10 hours the night before so we can screen you for cardiovascular risk factors like diabetes or high cholesterol which require a fasting blood sample.*

*If a child is coming in for a wellness visit please make sure you bring the child's updated immunization or shot record.*

*Please bring an updated list of medicines with you.*

*If you have Diabetes or High Blood pressure it will be extremely useful if you can bring the blood sugar and blood pressure logs or measurements with you.*

*We can help facilitate the process of moving your previous records to our office, please let us know if you are interested in doing so.*

*Kindly notify us if you are running late, so we can make necessary schedule adjustments and if you wish to cancel your appointment please notify us so we can cater to other patients needs.*

*Please feel free to let us know how we can better serve you.*

*Hope you have a fruitful visit...*

*Stay healthy and have a blessed day!*

*Dr.Nair*

**SAI PRIMARY CARE**

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Sex M / F Social Sec# \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Name of Policy Holder: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ WK Ph: \_\_\_\_\_

Social Sec. # \_\_\_\_\_

Home Telephone#: \_\_\_\_\_ Cell Telephone #: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Relationship to Pt.: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE – Effective: ___/___/___	Secondary Insurance – Effective: ___/___/___
Insurance Co. Name: _____	Insurance Co. Name: _____
Group/ Plan # _____	Group/ Plan # _____
Policy/Member# _____	Policy/ Member # _____
Subscriber Name: _____	Subscriber Name: _____
Claim Address: _____	Claim Address: _____
_____	_____
_____	_____
_____	_____

The above information is true to the best of my knowledge. I authorize treatment for the individual above or myself and I understand that I am ultimately responsible for changes associated with medical services and authorize the physician and the clinic to release any information required to process my insurance claims. I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted disease, sickle cell anemia, or other sensitive information. I also authorize my insurance to directly pay The Prestige Medical P.A.

\_\_\_\_\_  
Patient/ Responsible Party Signature

\_\_\_\_\_  
Date

**SAI PRIMARY CARE**

**PATIENT REGISTRATION FORM (CONT)**

Sai Primary Care is committed to providing you with the best possible care. If you have medical Insurance we are eager to help you receive your maximum Allowable benefits. In order to achieve these goals, we need you assistance, And you understanding of our payment policy.

1. **CONTRACTED INSURANCE:** All insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits and deductible are your responsibility. Payment for this is expected within 30 days from receipt of your statement.
2. **CO-PAYS:** All co-pays are expected at the time the service is rendered.
3. **NON-CONTRACTED INSURANCE:** If your insurance company is not contracted with SAI Primary Care will provide you with a claim to sent to your insurance fore reimbursement. All Third Party Payers (motor vehicle accident insurance) are considered non-contracted.
4. **METHOD OF PAYMENT:** We accept cash, VISA, or MasterCard.
5. **PAYMENT ARRANGEMENTS:** We understand that there may be times when financial difficulties come upon us without warning. Under special circumstances temporary payment arrangements may be made if approved in advance. Accounts on a temporary payment plan are required to make payment each and every month. Missed payments could result in collections. Accounts on a payment plan also must continue to pay at the time of the services. Our goals are to help you from attaining a greater debt and to assist you by keeping your account at a manageable level.
6. **RETURN CHECKS:** There will be a \$25.00 charge for all return checks.
7. **SERVICE FEE:** There is an interest fee accrued on ALL accounts with balances 60 days and over, regardless of payment arrangement or secondary insurance statue.
8. **DIVORCED, SEPARATED, OR BLENDED FAMILIES:** In order to keep accounts clean and eliminate any embarrassing or uncomfortable situation for you, we have chosen NOT to become involved in any agreements, understanding, and/or court order regarding reimbursement from the absent parent. Payment is required at the time of service. Reimbursement from absent parent is your responsibility.
9. **NO SHOW/CANCELLATION POLICY:** There may be a fee for no-show appointments or cancellation of appointments with 24-hour notice.

If you have any questions about the above information or any uncertainly regarding insurance coverage, Please don't hesitate to ask us. We are here to help you.

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Patient/Responsible party Signature

Date

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Patient's Name

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Date of Birth

# Sai Primary Care

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Phone number: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_

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## IMMUNIZATIONS

## YEAR

- |                                      |       |
|--------------------------------------|-------|
| <input type="checkbox"/> TD          | _____ |
| <input type="checkbox"/> MMR         | _____ |
| <input type="checkbox"/> PNEUMOVAX   | _____ |
| <input type="checkbox"/> INFLUENZA   | _____ |
| <input type="checkbox"/> HEPATITIS B | _____ |

## SCREENINGS

Last Pap Smear \_\_\_\_\_  
Last Colonoscopy \_\_\_\_\_  
Last Mammogram \_\_\_\_\_  
Last Prostate Screening \_\_\_\_\_  
Last DEXA Scan \_\_\_\_\_  
Last Physical \_\_\_\_\_

Do you have a Living Will?  YES  NO

## Medical Problems:

- |   |   |
|---|---|
| <input type="checkbox"/> Vision problems        | <input type="checkbox"/> Diverticulosis                     |
| <input type="checkbox"/> Hearing problems       | <input type="checkbox"/> Hepatitis B/C                      |
| <input type="checkbox"/> Bleeding from the nose | <input type="checkbox"/> Chickenpox                         |
| <input type="checkbox"/> Pain – tooth           | <input type="checkbox"/> Abdominal pain                     |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Pain in the joints                 |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Tingling/numbness                  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Headaches                          |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Seizures                           |
| <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Weakness                           |
| <input type="checkbox"/> Abdominal Pain         | <input type="checkbox"/> Trouble sleeping                   |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Urinary tract infection            |
| <input type="checkbox"/> Tobacco                | <input type="checkbox"/> Urinary Incontinence               |
| <input type="checkbox"/> Alcohol                | <input type="checkbox"/> Depression                         |
| <input type="checkbox"/> Drugs                  | <input type="checkbox"/> Anxiety/Panic attacks              |
| <input type="checkbox"/> Fractures              | <input type="checkbox"/> Sexually Transmitted Diseases      |
| <input type="checkbox"/> Tattoos                | <input type="checkbox"/> Blood or blood product transfusion |

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- **List of surgeries**                      Year                      Reason
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_

- **Hospitalizations**                      Year                      Reason
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_

- **Current List of medications**                      Dosage                      Number of times a day
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
  6. \_\_\_\_\_
  7. \_\_\_\_\_

- **Herbal Supplements**
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

<b>Family History</b>	<b>Y/N</b>	<b>Relation</b>
Cancer:	_____	_____
Heart disease:	_____	_____
Stroke:	_____	_____
Diabetes:	_____	_____
High Blood Pressure:	_____	_____
Seizures:	_____	_____
Mental Illness:	_____	_____

**Occupation:** \_\_\_\_\_

**Marital Status**    Married                       Single                       Widow

**Please list any specific concerns you wish to discuss with your physician:**  
\_\_\_\_\_

## SAI Primary Care

### Acknowledgement – Notice of Private Practices (HIPPA)

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

1. I authorize the use or disclosure of the above name individual's health information as described below.
2. I understand the Health information Portability and accountability Act of 1996 (HIPPA) have certain rights to privacy regarding my protected health information. I understand that this information can be used to:
  - Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
  - Obtain payment from third party payers.
  - Conduct normal healthcare operations such as quality assessments and physician certifications.
3. The type and amount of information to be used or disclosed is as follows:  

_____ Complete health records	_____ Labs results/X-ray reports
_____ Physical exam	_____ Consultation reports
_____ Immunization record	
_____ Other (please specify): _____	
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.
5. I have received, read and I understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a correct copy of the Notice of Privacy Practices.
6. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payments or healthcare operations.
7. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of witness

Date: \_\_\_\_\_

Date: \_\_\_\_\_

PRESTIGE MEDICAL PA  
(SAI PRIMARY CARE)  
9 2 2 3 B R O A D W A Y , S T E # 1 0 7 , P E A R L A N D T X . 7 7 5 8 4

**P A T I E N T A U T H O R I Z A T I O N T O  
D I S C L O S E P E R S O N A L H E A L T H I N F O R M A T I O N**

**Patient:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Sai Primary Care is authorized to **furnish to / receive from** (circle desired choice):

Name of Physician/Health Care Facility: \_\_\_\_\_

For the Purpose of: CONTINUITY OF CARE

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release **POTENTIALLY SENSITIVE INFORMATION**, which may include information concerning my treatment of mental illness, drug use/dependency communications to social workers and/or psychotherapies, psychologists, if any.
  
- I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

\_\_\_\_\_  
\_\_\_\_\_

I release Prestige Medical P.A. and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Prestige Medical P.A. provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

\_\_\_\_\_  
Patient Signature (Parent's Representative if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date