Goshen Medical Practice - Dicky Bhagat, MD
2240 Karisa Drive Suite 1 ● Goshen, IN 46526 ● Ph 574-534-6757

Please Fill Form Completely on both Front and Back. Mark N/A if not applicable

PATIENT INFORMATION

Last Name _____ First _____ MI _____

Street Address _____City/State_____Zip_____
(If P.O. Box, please also give street address)

Home Phone _____Cell Phone _____ Email _____

Date of Birth _____Social Security # _____ Sex □ M □ F

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact: Name _____ Relation _____

Address _____Phone _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Phone _____

Business Address _____

Employee Status: □ Full Time □ Part Time □ Not Employed □ Self Employed □ Retired

Student Status: □ Full Time □ Part Time □ Not a Student

SECONDARY CONTACT INFORMATION

Spouse's Name_____DOB_____ Social Security #_____

Employer Name _____ Phone _____

Business Address _____

INSURANCE

Does the patient have insurance? □ Yes □ No (Please present your cards so that copies can be made)

INSURED PERSON (IF NOT THE PATIENT)

Name_____DOB_____ Phone_____

Street Address _____City/State_____Zip_____

Relationship to Patient_____Employer_____

PHARMACY

Name and location of your local pharmacy _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have made with the insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature_____ Date _____

RELEASE CONSENT FORM

INITIAL WHERE INDICATED

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. INITIALS:_____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIALS:_____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize my physician who treats me to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorized benefits be made directly to my physician treating me. INITIALS:_____

CONSENT TO PHOTOGRAPH: I authorize Goshen Medical Practice to take my photograph and keep it on file for use in my medical records. INITIALS:_____

REFILLS: I understand I need to allow **48 hours** for refill request to be processed. INITIALS:_____

MAIL –IN PRESCRIPTIONS: I understand it is my responsibility to mail in my prescriptions. INITIALS:_____

FINANCIAL POLICY: I received and reviewed the financial policy of Goshen Medical Practice. INITIALS:_____

HIPPA POLICY RECEIVED: I have received a copy of Notice of Privacy Practices. INITIALS:_____

Your health information is protected by federal law and it is important to us that private information about you is shared only in the manner that you wish, and only with those with whom you would wish us to share it. The following sections pertain to your consent for us to communicate and share your private information. They are optional and you are not obligated to give us permission to share your information.

CONSENT TO LEAVE MESSAGES: I give consent and authorization for the medical and billing staff of my physician's office to leave private information about me or for me on my answering machine or voicemail via the telephone number(s) listed. I understand that I may revoke this privilege at any time by submitting my request in writing to this office.

INITIALS:_____

CONSENT FOR EMAIL CORRESPONDENCE: I give consent and authorization for the medical and billing staff of my physician's office to correspond to the below email address, private information about me or for me. I understand that I may revoke this privilege at any time by submitting my request in writing to this office.

Email_____ INITIALS:_____

CONSENT TO SHARE INFORMATION: I give consent to share my private information with others: Please provide us with the names and phone numbers of any people with whom you wish for us to be able to share information about you, such as spouse, family member or friends:

INITIALS:_____

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

I do not want my private information shared with any family members or friends, (please check here) □

WELLNESS VISITS

I understand that if want my claim to be filed as a wellness visit I need to inform the clinical staff prior to my services being rendered as Goshen Medical Practice is unable to change a diagnosis on a claim after a claim has been filed. I also understand that even though I request a visit be filed as a wellness or routine visit Goshen Medical Practice may not be able to honor this request. INITIALS: _____

ADVANCED DIRECTIVE

1.Do you have a living will? □ Yes □ No
2.Have you appointed a HC Rep □ Yes □ No
3.. Have you given anyone Power of Attorney? □ Yes □ No

Signature_____ Date _____