Kalpana Thakur, M.D. PA

4108 W Spring Creek Parkway, Suite E200, Plano, TX 75024

Patient Information		
Last Name:	First:	Middle:
Date of Birth:	Age:	Sex: M F
Marital Status: _ Single	_ Married	_ Other
S.S. Number	Home phone:	Mobile:
Street Address:	City:	State: Zip
Employer:	Work Phone Number:	Occupation
Referring Physician:		Phone:

Insurance Information		
Primary Insurance Name:	Policy#:	Group#:
Policyholder's Name:	Date of Birth of Policyholder:	
Policyholder's SS Number:	Relationship to Patient: _ self _ Spouse _ Child _ other	
Place of Employment:		
Address (if different than patient):		
Secondary Insurance Name (if applicable):	Policy#:	Group#:
Policyholder's Name:	Date of Birth of Policyholder:	
Policyholder's SS Number:	Relationship to Patient: _ self _ Spouse _ Child _other	
Place of Employment:		
Address (if different than patient):		

Emergency Information	
Contact Name(not living at same address):	Relationship to you:
Address:	
Home number:	Work Number:

Insurance Authorization and Assignment (please read and sign): I hereby authorize Kalpana Thakur, M.D. PA to apply foerbenefits on my behalf for covered services rendered by Kalpana Thakur, M.D. PA. I request my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kalpana Thakur, M.D. PA or the insurance company to release any information required to process my claims.

______________________________ ________

Patient Signature (Parent or Guardian if patient is under age 18) Date

Name ___________________________

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Authorization

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co pay and/or percentage that the insurance company is not liable for on the day of your visit. In the event your insurance company has not pain within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from you primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain your payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency that will leave you liable for additional expenses incurred if applicable. I, ___________________, have fully read and understand the about statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and I have the right to refuse these services.

____ _______________

Signature Date

____

Witness

I request that payment of authorize Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits are payable for related services.

____ ______________

Signature Date

Medicare Lifetime Authorization

HIC#__________________

Medicare Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related medial claim. I request that payment of authorized benefits by made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician organization to submit a claim to Medicare for payment.

Signature:___________________________________ Date: ______________

Printed Name: ________________________________ Relationship: ________________________

Witness: ____________________________________ Address: _____________________________

If signed by other thn beneficiaty, state reasons: ____

____

____

Name ____________________________

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OFFICE POLICY

Our goal is to provide our patients with excellent care!!!!

Insurance information will be verified prior to initial appointments. Please notify us of any changes that occur with your insurance coverage in the future.

Your insurance co-payments, co-insurance, and any outstanding balances are due at check-in. We accept cash, check or charge card – Visa, Master Card, Discover, and American Express ($20.00 will be charged for each returned check).

If you do not have insurance, of if your insurance deductible has not been met, you will be expected to pay for your visit at the time of your visit. For insured patients, we will file the insurance claim so that your payment is applied to your deductible.

Patients are ultimately responsible for all fees. If your insurance does not pay, we will bill you and expect payment in full. A payment schedule can be worked out if you request one.

If you cannot keep an appointment, we ask that you give us 24 hours notice.

I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THESE OFFICE POLICIES.

________________________________ ____________

Patient Signature Date

Name ____________________________

Kalpana Thakur, M.D. PA

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Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, _________________________, have received a copy of Dr. Kalpana Thakur's Notice of Privacy Practices for review and I am entitled to a copy for my records upon my request.

________________________________ ___________

Patient Signature Date

Name ______________________

Kalpana Thakur, M.D. PA

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Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Any health information Kalpana Thakur, M.D. P.A. collects or receives about you may be disclosed to the following persons:

____
Name of person / relation

____
Name of person / relation

____
Name of person / relation

Use and Disclosure of Information:

____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Kalpana Thakur, M.D. PA.

____ I do not authorize any information to be disclosed to any other parties except those parties outlined in the *Notice of Privacy Practices*.

If you have an answering machine or voice mail, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kalpana Thakur, M.D. PA.

_______YES _______NO _______N / A

If "NO", how may we contact you regarding this information?

____

Expiration Date of Authorization

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

________________________________ ________________________________
Signature of Patient or Legal Representative Date

________________________________ ________________________________
Print Name of Patient or Legal Representative Print Name of Witness

Name ____________________________

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Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home telephone __________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to mail to my work/office address

☐ Work telephone __________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other ___________________________

____

____
Patient Signature

____
Date

____
Print Name

____
Birth date

Name ____________________

Kalpana Thakur, M.D. PA
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New Patient Form

(Please bubble in all that apply)

Past Medical History

Abdominal pain	Yes	No
Acne	Yes	No
ADHD-hyperactive/impulsive	Yes	No
Allergic rhinitis	Yes	No
Anxiety disorder	Yes	No
Aortic stenosis	Yes	No
Asthma	Yes	No
Atrial fibrillation (Irregular heart beat)	Yes	No
Back pain	Yes	No
BPH - Enlarged Prostrate	Yes	No
Bronchitis	Yes	No
Coronary Artery Disease(CAD)	Yes	No
Cancer, colon	Yes	No
Cancer, leukemia	Yes	No
Cancer, prostate	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Deep Venous Thrombosis (DVT)	Yes	No
Diabetes	Yes	No
dysphagia (difficulty swallowing)	Yes	No
eczema	Yes	No
Emphysema	Yes	No
ESRD -End stage renal disease	Yes	No
GERD	Yes	No
Glaucoma	Yes	No

Bubble sheet 1

Name ______________________

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New Patient Form

(Please bubble in all that apply)

Past Medical History

Gout	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
Hyperlipidemia (High cholesterol)	Yes	No
Hypertension (High blood Pressure)	Yes	No
Hypothyroidism	Yes	No
Iron deficiency anemia	Yes	No
Irritable bowel syndrome	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Lupus	Yes	No
Neuropathy	Yes	No
Osteoarthritis	Yes	No
osteoporosis	Yes	No
PACEMAKER	Yes	No
Parkinson's disease	Yes	No
pulmonary embolism	Yes	No
Rheumatoid arthritis	Yes	No
seizures	Yes	No
sleep apnea	Yes	No
Stroke	Yes	No
tinnitus	Yes	No
vitamin B-12 deficiency	Yes	No

Other ____

Bubble sheet 2

Name ________________________

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New Patient Form

(Please bubble in all that apply)

Surgical History

adenoidectomy	Yes	No
appendectomy	Yes	No
back surgery	Yes	No
bladder suspension, unspecified	Yes	No
breast augmentation	Yes	No
breast biopsy	Yes	No
breast lump removed	Yes	No
CABG	Yes	No
cataract	Yes	No
C section	Yes	No
cervical fusion	Yes	No
cholecystectomy	Yes	No
colostomy	Yes	No
gastric bypass	Yes	No
heart stent	Yes	No
hernia repair	Yes	No
Hip surgery	Yes	No
hysterectomy abdominal	Yes	No
knee replacement	Yes	No
rotator cuff tear repair	Yes	No
tonsillectomy	Yes	No
tubal ligation	Yes	No
TURP	Yes	No

Other ____

Bubble sheet 3

Name ______________________

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New Patient Form

(Please bubble in all that apply)

Social History

	Yes	No
Alcohol:	Yes	No
Caffeine:	Yes	No
Drug use:	Yes	No
Exercise:	Yes	No

Occupation:

Full time   Part time   Self-employed   Unemployed

Marital Status:

Single   Married   Divorced   Widow   Life Partner

Children: Boys: ___ Girls:___

Smoking: Yes No

Pets: Yes No

Family History

Father	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Mother	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Siblings	Hypertension	Cancer	Diabetes	Heart Disease	Stroke

Paternal:

Grand father	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Grand mother	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Uncle	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Aunt	Hypertension	Cancer	Diabetes	Heart Disease	Stroke

Maternal:

Grand father	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Grand mother	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Uncle	Hypertension	Cancer	Diabetes	Heart Disease	Stroke
Aunt	Hypertension	Cancer	Diabetes	Heart Disease	Stroke

Bubble sheet 4

Name ____________________________

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Current List of All Medication:

Name: Dosage:

1. --

2. --

3. --

4. --

5. --

6. --

7. --

8. --

9. --

10. --

Name ____________________________

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Names of all Doctors that you see

Name: Type of Doctor Phone Number

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____