PATIENT INFORMATION

Patient Name_____ Date:_____

Address_____ City_____State____ ZIP_____

SS#_____ Birthdate_____Home Phone _____

Are you a full time student? Yes___ NO ____

Patient or Parent's Employer _____Work Phone _____

Business Address _____ City _____State _____ZIP _____

INSURANCE INFORMATION

Primary Insurance_____ ID#_____

Policy Holder Name _____Policy Holder DOB_____

Policy Holder Relationship _____Policy Holder SS# _____

Employer_____Work Phone _____

Secondary Insurance_____ ID#_____

Policy Holder Name _____Policy Holder DOB_____

Policy Holder Relationship _____ Policy Holder SS# _____

Employer_____ Work Phone _____

I hereby authorize Uma Sundaram M.D., to release such information required by my attorney and/or insurance company to secure my insurance benefits.

I hereby assign my insurance benefits herein specified and otherwise payable to me, not to exceed the doctor's fee. I understand that I am financially responsible for services not covered or deemed medically necessary by my insurance carrier.

_____Date _____

Signature of patient(or parent/guardian if minor)

Authorization For Release of Information

Please complete assignment of benefits on reverse side of this form.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulates how your protected Health Information (PHI) is "Used and Disclosed". The regulations are being enforced to protect your privacy, and Uma Sundaram, M.D. is committed in complying with all applicable laws and regulations. By checking the appropriate lines below, you are allowing Uma Sundaram, M.D. to release limited health care information. You may revoke this consent at any time, in writing, to our facility.

I, _____ give my consent to Uma Sundaram, M.D. to

speak with family members/spouse regarding office visits, procedures, appointment scheduling, collection of demographic information, and insurance billing requirements or billing inquiries. Please list all person(s) whom we are to release this information to, and their relation to you:

_____

_____

_____

_____ _____

Print Patient Name or Legal Representative Signature

_____ _____

Date Witness/Office Staff Signature

Please note, all requests for disclosure of medical records outside of our facility to anyone other than the referring physician, will require the patient to complete and sign an "Authorization for Health Information Disclosure" form.

Please complete assignment of benefits on reverse side of this form.