# HARPREET SINGH, M.D. INC - PATIENT REGISTRATION FORM

**Patient Information**

First name: _____ Last name: _____ Middle Initial: _____
Address: _____ City, State, Zip _____
Home phone:(__) _____ Work phone:(___) _____ Cell: (___) _____
Birth Date: _____ Age:_____ Soc. Sec: _____ Sex: □ Male □ Female
Employment Status: □ Full Time □ Part Time □ Retired Email address: _____
Name of Employer:_____ Phone: _____
Address:_____ City, State, Zip: _____
***Preferred Pharmacy:*** _____
***Primary Physicians*** Name:_____ Phone: (___) ___-_____
Address: _____ City, State, Zip_____
***Referred by.*** Doctor_____Attorney _____ Insurance Co._____Worker's comp _____
Referral:_____ Phone: (__) _____
Address: _____ City, State, Zip_____
***EMERGENCY CONTACT*** _____Phone: (___) _____

**Financial Responsibility (complete if other than patient)**

First name: _____ Last name: _____ Middle Initial: _____
Address:_____
City, State, Zip: _____
Home phone: (___) _____Work phone: (___)_____Cell: (___) _____
Birth Date:_____ Soc. Sec: _____

**Insurance Information (please provide insurance card)**

Name of Policy Holder:_____ Policy Holder Birth Date:_____
Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID:**_____
Address (if different than patient's):_____
Name of Policy Holder's Employer:_____ City, State:_____
Name of Insurance Company:_____
Address:_____ City, State, Zip_____

**Secondary Insurance Information (please provide insurance card)**

Name of Policy Holder:_____ Policy Holder Birth Date:_____
Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID:**_____
Address (if different than patient's):_____
Name of Policy Holder's Employer: _____ City, State:_____
Name of Insurance Company:_____
**Address:**_____ **City, State, Zip**_____

_____ _____ _____
Patient Signature Insured or Guardian Signature Date

**HARPREET SINGH, M.D. INC - Financial & Office Policies**

Patient Name: _____ DOB: _____
Address: _____ Home Phone#: _____
_____ Work Phone #: _____
Emergency Contact Name: _____Phone#:_____
Relationship to patient: _____

**Payment Policy:**

Payment is expected at time of service. Your co-pay, coinsurance, and/or deductible is due at time of visit. We accept ***cash only*** as a form of payment. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

_____
(Initials)

**Insurance Policy:**

We will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.

For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.

Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance or address changes.

_____
(Initials)

**Non-Covered Service Policy:**

Certain services performed by our office are NOT COVERED by all insurance plans. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

_____
(Initials)

**Medical Records:**

Should you request a copy of your medical records for a nominal fee. Please allow our office 7-10 business days for completion.

_____
(Initials)

**Delinquent Accounts Policy:**

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. The patient or guardian is responsible for payment of such collection fees and costs, including but not limited to reasonable attorney's fees, court costs, and service fees. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

_____
(Initials)

**Late Arrivals:**

In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances. _____

(Initials)

**Forms Policy:**

Should you request our office to complete forms on your behalf for disability, work status, jury duty, FMLA, OMV, etc., there will be a charge of $20.00 per form. Payment of this charge is expected at time of completion.

(Initials)

**Appointment Cancellations/No Shows/Reschedules:**

There is a **$500.00 Consultation charge and $100 follow-up appointment charge** for patients who don't cancel or no show for an appointment without giving 72 hours notice. We understand unusual circumstances may arise. Please contact our office as soon as possible. _____

(Initials)

**Prescriptions:**

Appointments are required for most medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

_____
(Initials)

**Returned Checks:**

Our office charges a $25.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

_____
(Initials)

**Referrals & Authorizations:**

If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be canceled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and prior authorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

_____
(Initials)

**Workers Compensation:**

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustor's Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

_____
(Initials)

**Liens:**

Were you involved in a personal injury/auto accident? _____

If yes, the following information is required:

Law office name and address, claim status, date of accident, and any additional insurance information. Please have this information available prior to your appointment time.

Please note, if you were involved in an auto injury, your medical insurance does not cover services related to that injury. By not providing us with current information, you may be responsible to pay any medical claims denied for personal injury relation.

_____
(Initials)

_____
(Patient/Guarantor **Printed Name)**

_____ Date_____
(Patient/Guarantor **Signature)**

# Harpreet Singh, M.D. INC

6010 Hellyer Ave, Ste 150
San Jose, CA 95138

## ASSIGNMENT OF BENEFITS and CONSENT TO TREAT

It is the policy of Harpreet Singh, M.D. that all patients are presented with an assignment of benefits statement to complete and sign when a patient checks in for appointments.

**PAYMENTS**

I hereby direct my health insurance plans/network/organization/plan, Medicare, or third party administrator of any such health care plan (hereinafter separately or collectively referred to as "Plans") to direct payments directly to Harpreet Singh, M.D. on my behalf, whenever possible. If you receive payment from insurance for our services, we must be paid immediately. Failure to do so might result in immediate referral to a collection agency.

**ASSIGNEMNT OF BENEFITS**

In consideration of services provided, I hereby assign, Harpreet Singh, M.D., the benefits due me My Health Care costs and expenses otherwise payable to me, for the Plan(s), policy or policies that I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.

**CONSENT TO TREAT**

I hereby authorize Harpreet Singh, M.D. and all persons acting as agents thereof, as well as all medical personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me.

Patient Name: _____

Patient/Legal Guardian Signature:_____

Dated: _____

# CONSENT TO DISCUSS OR RELEASE MEDICAL INFORMATION

I, _____.give Dr. Singh and his office permission to discuss and/or disclose my medical history and information with the following people (e.g. family members):

1)

2) _____

3) _____

***Please select all that apply. Where you list more than one communication option, please indicate which you prefer.***

☐ **Phone** Preferred

I want you to contact me by telephone at _____

☐ Do D Do not leave messages on my answering machine.

☐ Do D Do not leave messages with any other person.

☐ **Mail** Preferred

Address: _____

_____

☐ **E-mail** Preferred

E-mail address: _____

☐ **Fax** Preferred

Fax number: _____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Signed: _____Dated: _____

Print Name:_____

If not signed by the patient, please indicate relationship: _____

# THE FOLLOWING NOTICE IS REQUIRED BY CALIFORNIA LAW

## Doctors and Facilities

You may be referred to one or more of the doctors or facilities listed below for services. Each of the doctors listed below has a financial interest with or provides services to one or more of the other doctors and/or facilities listed.

## Patient's Freedom of Choice

You are free to choose any doctor or organization you wish for obtaining services that may be ordered or requested for you by any of the doctors listed below. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you.

Potential sources of information concerning alternatives can also be obtained from the Yellow Pages, the internet, or the county medical association.

The following address is provided for the filing of any complaints relevant to this notice or the services provided:

Medical Board of California,
2005 Evergreen Street, Suite 1200, Sacramento, CA 95815

**Doctors and Facilities:**

Silver Creek Surgery Center LLC
Harvinder Mundh MD Inc.
Harpreet Singh MD Inc. (OBA- Mind and Body Pain Clinic)

**I hereby acknowledge receipt of this notice.**

**Patient's Name:**_____ **Date:**_____

**Patient's Signature:**_____

# AUTHORIZATION FOR USE AND / OR DISCLOSURE OF PATIENT HEALTH INFORMATION TO HARPREET SINGH, M.D. INC

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Telephone: _____

I hereby authorize: _____
Name of Disclosing Party

_____
Address

_____
City State ZIP Fax

To Disclose To: Dr. Harpreet Singh, M.D.
6010 Hellyer Ave. Suite 150
San Jose, CA 95138
Phone: 408-356-5900

I understand that the health care provider or health plan identified above may not condition treatment, payment, enrollment or eligibility for benefits upon my signing this authorization.

DURATION: This authorization shall become in effect immediately and shall remain in effect until _____ or for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of Information is to be disclosed:

Records:

☐ MEDICAL/HEALTH INFORMATION ☐ DRUG/ALCOHOL INFORMATION

☐ PSYCHIATRIC INFORMATION ☐ RESULTS OF AN HIV BLOOD TEST

☐ OTHER HEALTH INFORMATION (Specify below): _____

_____

_____

The requester may use the health information authorized on this form for continuity of Care.

Signature: _____ Date: _____

HARPREET SINGH, M.D. INC
6010 Hellyer Ave #150
San Jose, CA-95138
Tel: 408.356.5900
Fax: 408.356.5902

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

What is the Open Payments Database?

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I acknowledge receipt of the above statement.

_____ _____

Patient's Signature Date

Harpreet Singh MD, Inc.
6010 Hellyer Ave, Suite 150
San Jose, CA 95138
Phone: (408) 356-5900 Fax: (408) 356-5902

**Good Faith Estimate Form**

Patient Name: _____
Condition Requiring Services: _____
Date of Service: _____

| | Service/Procedure | Gross Charge |
|---|---|---|
| | OFFICE CONSULTATION | $1,482.76 |
| Total Estimated Gross Charges Procedures/ Service Booked: | | $1,482.76 |

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give **patients who do not have Insurance or who are not using insurance** an estimate of the bill for medical Items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and ambulatory surgery center fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Patient Signature: _____ Date: _____