Vinay R. Shah, M.D., FACOG & Sukhdeep Singh, M.D.

Obstetrics & Gynecology

Today's Date ___/___/___

Last Name	First Name	Middle Name

Street Address	City	State	Zip Code

E-Mail Address	Home Phone	Social Security Number	Birthdate
	( )		___/___/19

Occupation	Employer	Employer Street Address

City	State	Zip Code	Work Phone
			( )

Spouse's First Name	Middle Initial	Spouse's Social Security Number	Spouse's Birthdate
			___/___/19

Spouse's Occupation	Spouse's Employer	Spouse's Employer Street Address

Spouse's Work City	State	Zip Code	Spouse's Work Phone
			( )

Primary Insurance Compnay	Address	Effective Date

Name of Insured (Guarantor)	Relationship to Patient:	Primary Insured's Birthdate	Policy Number	Group Number
	Self ❑ Spouse ❑ Parent ❑			

Secondary Insurance Company	Address	Effective Date

Name of Insured	Relationship to Patient:	Secondary Insured's Birthdate	Policy Number	Group Number
	Self ❑ Spouse ❑ Parent ❑			

Medicare Number	Other Insurance Coverage

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical benefits to Vinay R. Shah, M.D., P.C. for services rendered by them, or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. Photocopy of this release shall be valid as the original.

Medicare Patients

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. Photocopy of this release shall be valid as the original.

Authority to Release Records

As per HIPAA Act of 1996, I acknowledge that I have been given the opportunity to read the "Notice of Privacy Practices" posted in this office. I further acknowledge that I have been given the opportunity to have a copy of this policy.

Family Physician / Local Pharmacy	Referred by:	**Payment for today's visit, or insurance co-payment is required at time of service.** **Method:** **Cash ❑** **Credit Card ❑**

Please Complete Side 2 of this Form.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Vinay R. Shah, M.D. and Sukhdeep Singh, M.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Vinay R. Shah, M.D. and Sukhdeep Singh, M.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Vinay R. Shah, M.D. and Sukhdeep Singh, M.D. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Vinay R. Shah, M.D. and Sukhdeep Singh, M.D. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email), wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date of Signature