

**T.M. KALRA, M.D.**  
**A PROFESSIONAL CORPORATION**  
**GASTROENTEROLOGY, GALLBLADDER,**  
**LIVER, PANCREATIC AND SWALLOWING DISORDERS**

NAME \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**\*Please mark preferred method of contact/which number we can leave a message on\***

PLEASE MARK RACE/ETHNICITY:

CAUCASIAN       AFRICAN-AMERICAN       HISPANIC/LATINO  
 ASIAN       AMERICAN INDIAN       OTHER

PREFERRED LANGUAGE \_\_\_\_\_

E-MAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S EMPLOYER \_\_\_\_\_

SPOUSE/INSURED BIRTHDATE \_\_\_\_\_

PHARMACY \_\_\_\_\_ LOCATION \_\_\_\_\_

NAME OF EMERGENCY CONTACT \_\_\_\_\_

RELATION TO YOU \_\_\_\_\_ PHONE# \_\_\_\_\_

REFERRED BY \_\_\_\_\_

**CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY:**

I hereby authorize T.M. Kalra, M.D. and /or staff to render whatever services is deemed necessary for the treatment of my medical condition. I hereby authorize and assign medical benefits to Dr. Kalra for services provided. I give permission to share medical information requested by my insurance company to process claims on my behalf. I have read and understand the **BILLING AND CREDIT POLICY** and the **MISSED APPOINTMENT POLICY** on the next page. I accept the financial responsibility for all medical charges incurred by me or my dependents. In the event that this account must be placed with a collection agency or attorney for collection, I agree to assume all financial obligation incurred for such fees

\_\_\_\_\_  
Signature of Responsible Party/Patient

DATE \_\_\_\_\_

## BILLING AND CREDIT POLICY

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

Dr. Kalra is contracted with many Preferred Provider Organizations (PPO's). You are responsible for finding out if he is contracted with your insurance company. In order for our billing service to submit a claim to your primary and secondary insurance company, please bring your insurance ID cards with you. You are responsible for any co-payment and unmet deductible at the time of service. If the office needs to bill for your co-payment there will be an additional charge of \$25 if not received within 3 business days of office visit \_\_\_\_\_ (*initial here*). If you have no insurance, or the service is not a covered benefit, then payment is due at the time of service. For your convenience, we accept cash, Master Card, VISA and checks.

There are costs involved in transfer of medical records. These may be billed to you if such services are requested by you, your insurance company, or another physician of your choice per Health and Safety Code Section 12311(b)-Evidence State Code 1158. \_\_\_\_\_ (*initial here*)

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

## MISSED APPOINTMENT POLICY

We try to keep our patients scheduled in a timely manner. We know that your time is valuable and therefore we do not double book appointments. When an appointment is given to you, the time is blocked off specifically for you. If you don't appear or cancel without sufficient notice (24 hours or more), it prevents us from trying to accommodate another patient. Thus cancelling without sufficient notice or not showing up for an appointment will incur a charge of \$50 \_\_\_\_\_ (*initial here*). Charges for canceling a procedure without a 3 business days notice are \$200 \_\_\_\_\_ (*initial here*). As a courtesy, our office staff tries to confirm appointments the day prior. However, sometimes circumstances arise that prevent us from calling. If you have any questions about your appointment day or time, we encourage you to call our office. Please do not rely on the confirmation call to remind you of your appointment.

Thank you for your cooperation and understanding.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL  
INFORMATION  
TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with the federal government privacy rule implemented through the Healthcare Portability Act of 1996 (HIPAA), and in order for your physician or the staff at Dr. Kalra's office to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

\_\_\_\_\_ I am aware of the HIPAA regulations (copy provided upon request)  
*(Initials)*

\* In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I ***do not*** authorize Dr. Kalra's office to release any or all information concerning my medical care to any individual except for physicians involved in my care.

-OR-

\_\_\_\_\_ I ***do*** authorize Dr. Kalra's office to release any or all information concerning my medical care to the following individuals in addition to physicians involved in my care.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date