

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 _____

E-MAIL _____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

SPOUSE/INSURED SOCIAL SECURITY # _____

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 \$15. _____ (*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 \$35. _____ (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