Patient Registration **Chart# _________________**

SUNIL MALHOTRA, M.D.

PATIENT INFORMATION

(Circle one)

NAME ____ MALE/FEMALE SSN#_________________________

ADDRESS____ DOB_______________________

CITY__________________________STATE _______ZIP_________________ MARITAL STATUS: (circle one) S M D W

HOME PHONE _____________________________RACE__________________

EMERGENCY PH #_________________________________NAME/RELATIONSHIP_______________________________

EMPLOYER INFORMATION

EMPLOYER NAME ____PH___________________________________

OCCUPATION_________________________________

PRIMARY INSURANCE INFO

INS CO NAME _______________________________________ POLICY #_____________________________________

POLICY HOLDER'S NAME____

DOB & SSN# (if different from patient)____________________________________

RELATIONSHIP TO PATIENT ____

SECONDARY INSURANCE INFO

INS CO NAME _______________________________________ POLICY #_____________________________________

POLICYHOLDER'S NAME____

DOB & SSN# (if different from patient).____________________________________

RELATIONSHIP TO PATIENT ____

PHARMACY INFORMATION

PHARMACY NAME____________________________________ PHONE # _________________________________

INSURANCE NAME______________________________________ ID _____________________________________

GROUP #____________________________ PCN #_______________________ BIN #__________________________

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that this information furnished by me is correct. I hereby authorize Dr. Malhotra to apply for benefits on my behalf for covered services rendered by him or by his order. I request that any insurance payment be paid to him directly for any other party/parties that accept this assignment. If there is any denial by my Insurance Companies, if applicable, I will be responsible for any unpaid balance due within 30 days or as per my agreement with Dr. Malhotra. In the event of my inability to make payment toward the balance it will be turned over to certified collection agency for the unpaid amount plus any other collection charges including but not limited to agency fees, attorney fees, court costs etc. That will be added on after denial form my insurance company have been received. The unpaid balance will also accrue interest of 1.5% per month. I permit a copy of this authorization to be used instead of the original. Goodman Medical Clinic will file the insurance claims, however we will not be able to contact your insurance company on your behalf regarding any denials.

Signature____Date__________________________

<u>GOODMAN MEDICAL CLINIC POLICIES</u>

- **<u>FMLA</u>** paperwork filled out by the doctor is **$45.00** to be paid at the time of service.
- Medical records are **$50.00** for the first **20** pages and an additional **$1** per page after 20.
- Medication refills require at least a **5 day notice. No exceptions to this rule will be entertained.**
- **<u>We Do Not</u>** treat chronic pain. Patients will be referred to pain clinics as Dr. Malhotra sees fit.
- Please call 24 hours in advance if you are unable to keep your appointment. A fee of **$25** will be charged for no-shows **if not notified a day before.**

<u>WE DO NOT ACCEPT CHECKS, UNLESS MAILED FOR PAYMENT ON ACCOUNT.</u>

Signature ____ Date____________________

I understand by signing that I agree to the terms and polices above for Goodman Medical Clinic.

GOODMAN MEDICAL CLINIC
SUNIL MALHOTRA, M.D.
470 Goodman Road
Southaven, MS 38671
Phone:(662)536-3330 Fax:(662)536-3329

Permission to Share PHI Authorization Form

I, ______________________________, do by my signature below give permission to share my personal medical information with the person(s) listed below.
I understand this permission is valid until revoked. If I wish to revoke it, I must do so in writing.

______________________________ ____________ _____________
Patient's Signature Date of Birth Today's Date

<u>Please print the information below:</u>

______________________________ _______________ ________________
Name of Person to share info with Their Date of Birth Phone #

____
Address

______________________________ _______________ ________________
Name of Person to share info with Their Date of Birth Phone #

____
Address