EXCEL PRIMARY CARE, PLLC
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:	City:	Home phone no.: ( )				
P.O. box:	State:	ZIP Code:	Social Security no.:			
Occupation: Cell phone no:	Employer:	Employer phone no.: ( )				
Referred to clinic by Dr.:	❑ Insurance Plan	❑ Hospital				
❑ Family	❑ Friend	❑ Close to home/work	❑ Google	❑ Other		
Other family members seen here:						
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )			
Social Security Number - -	Relation to patient:					
Occupation:	Employer:	Employer address:	Employer phone no.:			

INSURANCE INFORMATION

Is this patient covered by any insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid/AHCCCS	❑ Blue Cross/Shield	❑ Commercial Ins.	❑ Other
Name of Primary Insurance:		Phone Number:			
Subscriber's name:	Subscriber's ID no.:	Birth date: / /	Group no.:	Network name:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance :	Subscriber's name:	Policy no.:	Group no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

Set up patient portal and sign up for news letter

EMAIL:

Next Page →

INSURANCE ASSIGNMENT AND FINANCIAL POLICY

Please read and sign this statement before we agree to accept assignment of benefits directly from your insurance company. This avoids any misunderstandings and facilitates the processing of your insurance claim. PLEASE BE AWARE THAT YOU MUST PROVIDE CORRECT AND ACCURATE INFORMATION REGARDING YOUR ADDRESS, INSURANCE, IF YOU PROVIDE OUR OFFICE WITH FALSE INFORMATION YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED DURING YOUR VISIT.

PAYMENT POLICY

- Each patient, and ***not their insurance company***, is responsible for the payment of all charged services.
- It is the patient's responsibility to know his or her own health plan. This includes making sure that the physician you are seeing is contracted participating provider for your health plan, knowing if the insurance is an HMO, PPO or Medicare replacement plan, if your policy is in effect, if maximum benefits exists and has been already used, etc.
  All charges not covered by your health plan are the responsibility of the patient. _____ please initial
- **Self pay:** Full payment is due at the time of service, before seeing the physician. Please note: the doctor's visit does not include: vaccinations, injections, tests, and procedures; therefore extra charges will apply if these are requested by the physician for your treatment.
- **Medicare:** You will be responsible for paying your annual deductible, co-payment, co-insurance and any **non-covered services.**
- **HMO, PPO, or Other Managed Care Participants:** Patients are responsible for meeting their annual deductible and co-pays at the time of service. You will be responsible for paying your co-insurance and charges for any **non-covered services**.
- **PATIENT'S RESPONSIBILITY to make sure we are contracted with their insurance and which laboratories to use/send specimens to. _____ please initial**
- **IF INSURANCE DOES NOT COVER TELEHEALTH IT WILL BE $95 .00 CHARGE. _____ Please initial**

Commercial Participants: Patients who are covered by private, commercial plans, in which our physicians are not contracted, are responsible for all fees. The balance left after payment from your insurance will be billed to you.

Medical records: There is a charge for any medical records requested by patients, attorneys, etc. There is no charge for transmitting records to another physician. Right to revoke/Re- Disclosure: We must receive a letter in writing stating that you want to revoke/re-disclose the release of medical records.

PATIENT AND/OR GAURANTOR AGREES TO PAY ALL COST OF COLLECTION INCLUDING ATTORNEY FEES, COLLECTION FEES AND CONTINGENT FEES TO COLLECTION AGENCIES OF NOT LESS THAN 35% OF THE DELIQUENT BALANCE, SUCH CONTINGENCY FEE TO BE ADDED AND COLLECTED BY COLLECTION AGENCY IMMEDIATELY UPON REFERAL OF YOUR ACCOUNT TO THE COLLECTION AGENCY OF OUR CHOICE.
BOUNCED CHECKS: There is a $30.00 charge for all bounced checks

FMLA/ Disability paperwork there is a $35.00/$50.00 charge.
For certain medication/Injection we will not be billing the insurance, there will be a flat charge of $20.00, that needs to be paid before administration;
B12, testosterone, Toradol, Rocephin injections $25.00

CANCELLATION POLICY

I understand and agree that I will give 24 hour business day notice if I am unable to make my scheduled appointment. A charge of $25.00 will be assessed to my account for missed or broken appointments without 24 hour notice.

PRIVACY STATEMENT

I understand that I have been given the opportunity to view the privacy policy. I understand that if I desire a copy, one shall be given to me by the office staff. The policy is located in the each exam room. I understand that Excel Primary Care participate in the State HIE. The policy is located in each exam room.

The patient and insurance information I disclosed in the demographic form is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Excel Primary Care, PLLC or insurance to release information required to process my claims.

_____ _____
Patients Signature or Legal Guardian Date

_____ _____
Office Staff Member Date

Next Page →

Excel Primary Care PLLC
3303 S. Lindsay Rd Suite 115
Gilbert AZ 85297

Date: _____

I understand that my insurance may or may not cover all conditions/counseling discussed during my visit. This may be due to being applied to my deductible or not being a covered benefit. Such conditions may include family counseling/planning, Biopsy, Excision, injections, immunizations. By signing this notification I understand that I will be fully responsible for any services that are not covered by my insurance.

I _____ authorize Excel Primary Care to leave a detailed voice mail regarding any medical matter on my home or cell phone _____. ☐ YES ☐ NO

HIPAA
Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of Excel Primary Care under HIPAA Laws and regulations.

Patient name: _____

Patient Signature: _____ Date: _____

Signature of Practice Employee_____

Next Page →

EXCEL PRIMARY CARE, PLLC

Dr. Meena Venugopal, MD

Board Certified in Family Medicine

3303 South Lindsay Road, Suite #115, Gilbert, Arizona 85296

Tel: 480-507-0604 ***Fax: 480-507-0592***

Dear Patient,

Please schedule your follow up visit to review any results. We will no longer be able to give those results over the telephone. This includes any labs, ultrasounds, CT scans or Biopsies.

It is your responsibility to make sure that you have a follow up appointment to discuss test results.

Thank you for allowing us to participate in your health care needs.

Sincerely,
Management

_____ _____

Patient Signature Date

Next Page →