NEW PATIENT FORM
NORTH DALLAS WOMEN'S CARE

NAME: _____
LAST FIRST

ADDRESS: _____
STREET CITY/STATE ZIP

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____

DATE OF BIRTH: ___ - ___ - _____ SEX: M / F SS #: ____-____-_____

EMAIL ADDRESS: _____

INSURANCE/RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE
POLICY HOLDER: _____
NAME DATE OF BIRTH

INSURANCE NAME: _____

ID NUMBER: _____ GROUP NUMBER: _____

CLAIM ADDRESS: _____ PHONE: (___) -_____-_____
STREET CITY/STATE ZIP

PREFERRED PHARMACY: _____
NAME STREET CITY/STATE ZIP

_____
SIGNATURE OF PATIENT/GUARDIAN

North Dallas Women's Care PA
Surekha Machupalli M.D.

Financial Responsibility

As advocates for our patients, we will make every effort to access the maximum benefits under your third party payer contract (insurance). As a patient in this office, you will receive treatment that is specific to the problems that are noted during your examination. In return, your financial responsibility for this treatment will be to the doctor. We will assist you in obtaining reimbursement from your third party payer for this responsibility.

It is important that you understand that your benefits contract may have an allowable amount for each procedure, this allowable is determined by the benefit contract you have with the company and does NOT always equal the doctor's fee. The third party payer may pay a percentage of the allowable. You are then responsible to the doctor for the payment of balance. This payment may include your deductible (if not already satisfied), the copayment and any remaining portion of the doctor's bill that is not covered (providing we are NOT contracted providers with the benefit payer). The portion estimated to be your responsibility will be due at the time of service.

Again, we assure you that we will make every effort to obtain benefits from your third party payer. We gladly process your claim but we request that you pay your estimated portion at the time services are rendered. We thank you for your confidence in our office and look forward to providing you with competent care and courteous service.

Sincerely,
Office Manager
North Dallas Women's Care P.A.

I have read the above statement and understand that I am financially responsible to Dr. Machupalli for all care and services provided to me

Name of Responsible Party: _____

Relationship to Patient: _____

Signature: _____

Notice of Privacy Practice

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practice for review. I understand that North Dallas Women's Care will not disclose my record to others unless I ask them to do so or unless the law authorizes or compels to do so.

Consent of Treatment

I hereby authorize North Dallas Women's Care to perform x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or any other diagnostic or therapeutic treatment or services deemed necessary by the medical provider.

Release of Medical Information

I hereby authorize North Dallas Women's Care to release information and/or copies of my medical records to physicians, any guarantor of payment on my accounts, insurance companies, and other third party payers.

Agreement to Pay Charges

I hereby agree to pay North Dallas Women's Care to total charges, on demand, for services rendered or any copayments or deductibles for which I am liable. I also agree that all charges for services not covered by any insurance companies are due at the time of services. I also agree to pay late charges of **$25.00** for any account not settled within 30 days of service, and interest on the account.

Assignment of Insurance Benefits

I hereby authorize and assign North Dallas Women's Care to receive all reimbursement benefits on all the insurance policies otherwise payable to me for this visit. I also authorize North Dallas Women's Care to submit insurance claims and apply insurance proceeds to North Dallas Women's Care bill and to make refunds to insurance companies if refunds are due under provisions of such insurance policies. I hereby authorize and direct payment to North Dallas Women's Care for any services provided during my care. I understand that I am financially responsible for charges not covered by my insurance company. I hereby authorize North Dallas Women's Care to endorse any checks or other payment instruments that have been made to my name.

I certify that I am personally empowered or duly authorized by the patient as the patient's agent to execute above.

_____	_____
Print Name of Patient	**Signature of Patient or Legal Guardian**
_____	_____
Patient Social Security Number	**Date**
_____	_____
Print Name of Legal Guardian	**Relationship to Patient**

<u>Office Policies</u>

North Dallas Women's Care, P.A

(972) - 943 - 9612

1. If there are any changes with your insurance, phone number, address, etc. please let us know at the time of your visit. **Please bring your insurance card with you for every visit.** All new patients **MUST** provide their ID or Driver's License at the time of visit. Failure to provide may result in appointment reschedule.
2. If something comes up and you feel you cannot keep your appointment for office visit or ultrasound, we do require a **24 hour notice in advance.** We charge a **$25 fee** for cancellation, reschedule, or no-show on the appointment date.
3. If you have a balance on your account, the full amount is due at the time of service or **no later than within 24 hours of your visit.** We do take credit cards, checks, and cash. All billing questions can be discussed with our billing specialists at the time of your visit.
4. Please arrive 15 minutes prior to the appointment time to complete any paperwork necessary.
5. If you have lab work done and you receive a bill for your lab services, we **cannot** help you because we did not bill you. We are working with our labs to make billing easier for all of us.
6. We do our best to respect your time and schedule, however, we also do our best to offer the best quality of care to each patient. For this reason, wait times may vary, but we assure you that the doctor will get to you as soon as possible. We ask that you be patient with us, and remain in your room as you wait for the doctor.
7. Please be considerate of others. We understand you may choose to bring your child with you, but please supervise them to ensure they are not disruptive to other patients and staff.

Signature: _____ Date: _____

Email: _____