VENKATA BODAVULA, MD FACS

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

General Patient Information

Today's Date _____

Patient Name (print): _____Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Sex: M F Other Height: _____ Weight: _____ Dominate Hand: R L

Occupation: _____ Employer: _____

Race: _____ Ethnicity: ◯ Hispanic ◯ non-Hispanic ◯ Decline to Answer

Reason for today's visit: _____ Date of Injury_____

1. How did this occur? _____
2. *Is this injury work related?* Yes No Date of Injury_____
   Is this a worker's compensation case?

   If yes, please explain: _____
3. Is this injury due to an auto accident? Yes No Date of Injury_____

   If yes, please explain: _____
4. Do you have an attorney? Yes No Date of Injury_____

   If yes, please explain: _____

Billing and Insurance (If not a work-related injury)

Primary Insurance holder: ☐ Self ☐ Other If other, insurance holder's name_____

Insurance holder's DOB: _____ Insurance holder's SS# _____-_____-_____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary/Family physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Location: _____

How did you learn about our practice? _____

If referred. Who referred? _____

CURRENT MEDICATIONS

Drug name	Dosage	Frequency	Reason or condition for taking medication.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST OF ALLERGIES	REACTION
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY AS OF TODAY)

HAVE YOU EXPERIENCED OR CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY AS OF TODAY)

_____ Chills	____Ringing in ears	____Diarrhea	____Muscle Weakness
_____Fatigue	____Chest Pain (respiratory)	____Vomiting	____Seizures
_____Fever	____Cough	____Dysuria	____Anxiety
_____Night Sweats	____Known TB exposure	____Frequent Urination	____Depression
_____Weight Gain	____Wheezing	____Hematuria	____Rash
_____Weight Loss	____Chest Pain (non-respiratory)	____Incontinence	____Nail Changes
_____Blurred Vision	____Heart Murmur	____Cold Intolerant	____Bleeding
_____Double Vision	____Irregular Heartbeat	____Heat Intolerant	____Bruising
_____Ear Drainage	____Abdominal Pain	____Difficulty Walking	____Food Allergies
_____Hearing Loss	____Constipation	____Poor Coordination	____Seasonal Allergies
_____Nose Bleeds	____Other: _____		

Have you ever had MRSA or MSSA that you know of? Yes_____ No_____

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES REASON OR CONDITION

YEAR_____ WHERE_____ _____

YEAR_____ WHERE_____ _____

YEAR_____ WHERE_____ _____

HAVE YOU HAD ANY DIAGNOSTIC STUDIES PERFORMED ON THE BODY PART BEING EXAMINED TODAY?

	Location	Date		Location	Date
X-ray	_____	_____	**Arthrogram**	_____	_____
CT	_____	_____	**EMG**	_____	_____
MRI	_____	_____	**Other**	_____	_____

CHECK ANY MEDICAL CONDITIONS YOU OR YOUR IMMEDIATE FAMILY HAVE NOW OR HAVE HAD IN THE PAST

	Self	Family		Self	Family		Self	Family
Anemia	_____	_____	**Hepatitis**	_____	_____	**Other** _____	_____	_____
Arthritis	_____	_____	**HIV**	_____	_____	**Cancer Type**_____	_____	_____
Gout	_____	_____	**High Blood Pressure**	_____	_____	**Kidney Disease**	_____	_____
Diabetes	_____	_____	**Sleep Apnea**	_____	_____			
Injectable _____			**C-PAP or BI-PAP used**_____					

SOCIAL HISTORY

	YES	NO		YES	NO
Have you ever smoked?	_____	_____	**Do you consume alcohol?**	_____	_____
Do you smoke now?	_____	_____	**Do you follow a routine exercise program?**	_____	_____

How many packs per day? _____

Program	Type	Frequency
_____	_____	_____

Patient Signature or Responsible Party_____

Date_____

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Dr. Venkata Bodavula as your health care provider. We are committed to building a successful physician-patient relationship. Please understand that payment for services is part of the relationship. Please ask if you have any questions about fees, our policies, or your responsibilities. It is your responsibility to notify our office of any changes to your patient information (i.e. address, name insurance, etc.). After reviewing the policies below please sign and date indicating you have read, understand and will adhere to the written policies.

Appointment: If you are unable to keep your appointment, we require that you contact our office. We request that you call to cancel your appointment at least 24 hours in advance, when possible. If you show up late your appointment may need to be rescheduled as we are on a time schedule.

Insurance Referrals: If your insurance company requires a referral, it is your responsibility for obtaining it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you come to your appointment without your referral, you will be required to reschedule. Referrals must be generated from your primary care physician or referring doctor.

Insurance: Your insurance is a contract between you and the insurance company. We are not a party to this contract. We will bill your insurance company (primary and secondary, if applicable). Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing the line below, you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance company.

Required Payment: You will be responsible for showing your insurance card at every visit. All copayments and past due balances are due at the time of check-in before seeing the physician or you will be required to reschedule your appointment. There is a $25.00 fee required for waterproof cast regardless of insurance. We accept cash or credit.

Self-Pay Accounts: Patients without insurance coverage, patients covered by insurance plans in which this office does not participate, or patients without an insurance card on file. Liability cases will also be considered self-pay accounts. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.
(Self-pay patient will be required to pay $150.00 at check-in. Depending on what your need is during the visit you should be prepared to pay up to $1000.00 or more. It is never our intention to cause a hardship to our patient, only to provide them with the best care possible.)

Motor Vehicle Accident (MVA) & Third-Party Billing: We do accept third-party billing, but you may become responsible for your bill if the third-party doesn't follow through with payments. You may receive an accident questionnaire from your insurance carrier that requires you to complete and return. If the questionnaire is not returned to your medical insurance company and/or we receive a denial of your claim, you will be responsible for payment in full.

Worker's Compensation: It is the patient's responsibility to provide our office staff with employer authorization, claim number, and contact information regarding a worker's compensation claim. If the claim is denied by the worker's compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the worker's compensation insurance denial letter. If your primary medical insurance carrier's claim is denied, you will be responsible for payments in full.

Outstanding Balance Policy: It is our policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made the account will be sent to the collection agency, attorney, and possible discharge from the practice. In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service.

Patient Name_____ Date_____

VENKATA BODAVULA, MD FACS

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my physician (or whomever he may designate) to administer medical treatment as is necessary for a patient in my condition. I hereby authorize Dr Venkata Bodavula to release any and all information acquired as the course of my examination or treatment which may be requested by guarantors, insurers, managed care or similar network organizations or payers of my account. In addition, I authorize payment of medical benefits to Dr Venkata Bodavula.

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I have been provided with a Notice of Privacy Practices that describes the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will provide a copy or any revised notice.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO ANOTHER PARTY

I also authorize Dr Venkata Bodavula to use and/or disclose certain protected health information (PHI) about me to the party or parties listed below.

Release of Information:

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information cannot be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

_____ _____

Signature of patient or legal guardian | Relationship to patient, if guardian

_____ _____

Print name of patient or legal guardian | Date