PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*)_____

Date of Birth: _____Age: _____ Male / Female Marital Status: S M W D

Address:_____

Phone Number _____Social Security # _____Driver's License #_____

E-Mail Address: _____

Employer _____Phone: _____

Employer Address: _____

Referring Physician:_____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party

Name: _____

Relationship to Patient: _____

Address:_____

Phone Number: _____ Social Security # _____

Employer: _____

Phone Number: _____Employer Address:_____

Emergency Contact: _____Phone Number: _____

Relationship: _____ HIPPA Information: YES/NO

Insurance Information

Insurance Company: _____

Phone Number: _____Address: _____

Group # _____Certificate or ID # _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____Phone Number:_____

Employer Address:_____

Insured's Social Security # _____ Date of Birth _____Male / Female

I hereby assign, transfer, and set over to Anshul Agarwal, MD/Anagha Agarwal, MD AlphaHealth Medical Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Dr. Anshul Agarwal, MD/Dr. Anagha Agarwal, MD provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

PATIENT CONSENT TO TREAT

I hereby give my consent to Dr. Anshul Agarwal, MD/Dr. Anagha Agarwal, MD and authorize her/him to provide my medical treatment. I understand that Dr. Anshul Agarwal, MD/Dr. Anagha Agarwal, MD will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Dr. Anshul Agarwal, MD/Dr. Anagha Agarwal, MD to perform any additional or different treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature(for minor): _____ Relationship: _____

Signature of Treating Provider: _____ Date: _____

RETURN THE FIRST TWO COMPLETED PAGES TO THE FRONT DESK

AlphaHealth
PRIMARY CARE CLINIC

Telemedicine Consent Form

Introduction

Telemedicine involves the use of electronic communication to enable healthcare providers at different locations. This information may be diagnosis, therapy, follow-up and/or education and may include any of the following

- Patient Medical Records
- Medical Images
- Live two-way audio & video

Electronic system used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improve access to medical care by enabling a patient to remain in his/her home
- Obtaining expertise of a distant doctor

I certify that this form has been fully explained to me. I have read it or had it read to me. I understand and agree to its contents. I am consenting to participating in the telemedicine examination. I authorize AlphaHealth Medical Associates doctors, nurses, and or other providers involved to perform procedures that may be necessary for my current medical condition.

Name Printed: _____

Signature: _____

Date: _____

AlphaHealth

PRIMARY CARE CLINIC

1014 E. Wheatland Rd Duncanville, TX 75116 Ph: 214-550-2330-Duncanville
255 W. Lebanon Rd Ste#116 Frisco, TX 75036 Ph: 469-405-0500-Frisco
7505 Glenview Dr Suite: 151 North Richland Hills, TX 76180 Ph: 817-284-9922-NRH
1251 E. Redbird Lane Ste: A Dallas, TX 75241 Ph: 214-377-0608- Redbird

Patient Name: _____ **DOB:** _____ **Last Four Of SSN:** _____

Name and complete mailing address of the person to receive your records is required to process this request.

Send copy of records to: **Send Copy of records From:**

AlphaHealth Medical Associates

Duncanville Fax: 214-550-2331 /Frisco Fax: 469-405-0501

NRH Fax: 817-284-9926/Redbird Fax: 214-432-1426

I understand that if the recipient authorized to receive the information is not a covered entitiy, e.g. Insurance Company or non-healthcare provider, the released informtion may no longer be protected by Federal & State regulations

The following information is requested and may be released:

All Records: _____ Lab Reports: _____

Progress Notes:____ Radioogy Reports:_____

ER Discharge Summary:_____ Medications:_____

Medical Summary:____ EKG Report:_____

Reason for Request: PCP Change: _____ Continuation of Care: _____

I hereby give my express consent to release all medical records regarding my treatment , including psychological or psychiatric treatment, drug abuse, Human Immunodeficiency Virus (HIV) infection including Acquired Immunodeficiency Syndrome (AIDS) or test for HIV or sexually transmitted disease (STD) by circling one or all of the above.

Description of the Purpose /or Disclosure: I understanf that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire the authorization to be in effect until . I further understand that I may revoke this authorization at any time by notifying Waterstone Wellness, inwriting. I understand that copies of records are subject to a $25.00 minimum fee.

_____

Signature of Patient/Representative **Date** **Phone Number**

AlphaHealth
PRIMARY CARE CLINIC

HIPPA Medical Release Form

Patient Name: _____

Date of Birth: _____

Today's Date: _____

I _____, give permission to AlphaHealth
(Patient Name)
Medical Associates to release my medical information, including test results, past medical history, appointment dates, to: **(Who Can receive this information)**

1.) **Name:** _____ **Contact Number:**_____
Relationship:_____

2.) Name: _____ Contact Number:_____
Relationship:_____

3.) Name: _____ Contact Number:_____
Relationship:_____

4.) Name: _____ Contact Number:_____
Relationship:_____

Patients Signature: _____ **Date:**_____

I understand I may revoke this authorization at any time, provided that the revocation is submitted in writing to the privacy officer at the practice.