Patient Information

Please print and use black ink Date:

Name: Age: Female: Male:
Single Married Divorced Separated Widow
Date of Birth: S.S. #: Spouse's S.S. #:
Primary Phone#: Other Phone#:
Address: Apt#: City: State: Zip:
Name of Spouse or Parents:

Patient's Occupation: Employer:
Employer's Address: City: State: Zip:
Phone: Ext.#:

Spouse's Occupation: Employer:
Employer's Address: City: State: Zip:
Phone: Ext.#:

Name of Primary Insurance Co.: Subscriber Name:
Insurance I.D.#: Group#:

Name of Secondary Insurance Co.: Subscriber Name:
Insurance I.D.#: Group#:

Referring Primary Care Physician: Phone:

Name of nearest relative or friend (for contact in case of need) not living with you:

Address (Street, City, State, Zip):
Phone:

Permanent Address (Winter Visitors):
City: State: Zip:

2034 E. Southern Ave., Ste. # T
Tempe, Arizona 85282
(480) 838-2277

SDMS, P.C.
Krishna M. Pinnamaneni, M.D.

Name: Date:

PLEASE READ AND SIGN. Do not cross-out or change wording in any way. Any defacing may invalidate this agreement. If you have questions, please ask the front office before signing:

I hereby authorize Drs. Pinnamaneni to release any and all medical, including dental, information to the named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review, and financial audit. Fees may be assessed for such copies. This authorization remains valid and effective from the date of signing. I understand that I may request a copy of this authorization.

I hereby assign to Drs. Pinnamaneni all money to which I am entitled for medical and/or surgical expense relative to the services rendered by the Doctor, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above indebtedness will be refunded to me when my bill is paid in full.

I understand that I am financially responsible to pay said Doctor(s) for charges not covered by this assignment of insurance payment. I further agree in the event of non-payment, I am responsible to pay for the services received and to bear the cost of collection, and/or court cost and reasonable legal fees, should they be required.

At my request, Drs. Pinnamaneni's staff and/or billing clerk explained to me all charges involved in detail to my satisfaction, and I am to ask or contact them for any further clarifications or details on charges involved before their services are rendered. I also acknowledge the receipt of Drs. Pinnamaneni policies and procedures brochure that I am to abide, and all my questions in regards to my medical care and my financial responsibilities are answered to my satisfaction.

I also agree it is my sole responsibility to provide this office with any changes or updates to my insurance coverage or personal information. I am aware that a copy of HIPPA guidelines is available for my review at any time in the front office. I agree to provide at least 48 hours notice for any appointment cancellation to avoid a fee. There is a $25 - $50 fee for failing to keep my appointment and for wasting a time slot for another patient. I understand that if I fail to make payment for services rendered my account may be turned over to a collection agency, and a 40% fee will be added to any balance.

Drs. Pinnamaneni makes no pretense of perfection and omniscience. Decisions about diagnosis and treatment are complex. Knowledge in medicine is imperfect, beyond any doctor's control. No diagnostic test is flawless. No drug is without side effect, expected or idiosyncratic. No prognosis is fully predictable. Drs. Pinnamaneni cannot guarantee any specific outcome.

If my insurance carrier's contract stipulated that I have to obtain a referral form before seeing a specialist such as Drs. Pinnamaneni, IT IS MY RESPONSIBILITY TO BRING THAT REFERRAL FORM WITH ME, PROPERLY COMPLETED AND SIGNED BY MY REFERRING DOCTOR. FAILURE TO OBTAIN MY COMPLETED REFERRAL FORM WILL CONSTRAIN DRS. PINNAMANENIY TO DENY THE PRACTICE'S SERVICES.

I read, understood, and received a copy of the above agreement (upon my request).

X

SIGNATURE OF INSURED, PATIENT, OR GUARDIAN

If someone other than patient is responsible for payment, please complete this section:

Full Name:

Address: City: State:

Business Phone: Home Phone: