Mittal Family Healthcare, Inc.

9360 No Name Uno, Suite 240
Gilroy, CA 95020

Phone: (408) 846-8100
Fax: (408) 846-8101

PATIENT REGISTRATION

Patient Name ____

Social Security Number ______________________ **Sex** ________ **Date of Birth** _____/_____/_____

Home Phone ______________ **Work Phone** ______________ **Cell Phone** ______________

Home Address ______________________ **City** ____________ **State** ______ **ZIP** ________

E-Mail Address ____

Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Widowed **Occupation** ______________

Employment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Full-time Student ☐ Part-Time Student

Employer Name (if employed) ______________________ **Business Phone** ______________

Employer Address ______________________ **City** ____________ **State** ______ **ZIP** ________

Race ☐ Caucasian ☐ African American ☐ Indian American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ Other

Primary Language ______________________ **Ethnicity** ______________________

First Emergency Contact ______________ **Relationship** __________ **Phone** ______________
Second Emergency Contact ______________ **Relationship** __________ **Phone** ______________

Pharmacy Name ______________________ **City** ______________ **Phone** ______________

If you are a minor or if you live with your parents

Father's Name ______________________
Occupation ______________________

Employer ______________________
Business Phone ______________________

Mother's Name ______________________
Occupation ______________________

Employer ______________________
Business Phone ______________________

Patient / Responsible Party Insurance Information

Primary Insurance ______________________
Policy Holder Name ______________________
Group Number ______________________
Policy Number ______________________
Relation to Patient ______________________
Social Security Number ______________________
Date of Birth ______________________
Address ______________________

Secondary Insurance ______________________
Policy Holder Name ______________________
Group Number ______________________
Policy Number ______________________
Relation to Patient ______________________
Social Security Number ______________________
Date of Birth ______________________
Address ______________________

The above information is true and best of my knowledge. I authorize payment of Medical benefits to *Mittal Family Healthcare, Inc.* for the services rendered.

____

Signature of Patient or Guardian (if minor) Date

Mittal Family Healthcare, Inc.

9360 No Name Uno, Suite 240
Gilroy, CA 95020

Phone: (408) 846-8100
Fax: (408) 846-8101

FINANCIAL POLICY / SIGNATURE ON FILE

NEW PATIENTS

AT YOUR INITIAL VISIT WE ASK YOU TO DEPOSIT $60 IF YOUR DEDUCTIBLE IS $300 OR MORE. ANY SUBSEQUENT VISITS WE ASK FOR THE BALANCE YOU OWE.

ESTABLISHED PATIENTS

AT THE BEGINNING OF EACH NEW CALENDAR YEAR (JAN 1) WE ASK YOU TO DEPOSIT $50 IF YOUR DEDUCTIBLE IS $300 OR MORE. IT WILL BE APPLIED TOWARDS YOUR DEDUCTABLE.

CO-PAYS

COPAYS MUST BE PAID AT EACH VISIT AND WE WILL BILL YOUR INSURANCE THE BALANCE.

MEDICARE

YOU MAY BE ASKED TO PAY YOUR 20% AT THE TIME OF SERVICE UNLESS YOU HAVE A SUPPLEMENTAL PLAN. IT WILL BE APPLIED TO YOUR CO-INSURANCE.

HOSPITAL CHARGES

WE WILL SUBMIT ALL HOSPITAL CHARGES TO YOUR INSURANCE COMPANY. PLEASE PROVIDE OUR STAFF WITH ALL INFORMATION NECESSARY TO ACCOMPLISH THIS. IF YOU FAIL TO PROVIDE US WITH YOUR INSURANCE INFORMATION YOU WILL BE RESPONSIBLE FOR YOUR BALANCE.

PLEASE STRIVE TO KEEP YOUR ACCOUNT CURRENT. SHOULD YOUR CHARGES BE MORE THAN 30 DAYS OLD, YOU WILL NEED TO MAKE PAYMENT ARRANGEMENTS WITH OUR OFFICE MANAGER.

THANK YOU.

GUNJAN MITTAL, M.D.
President, Mittal Family Healthcare Inc.

I have read the above financial policy and understand the content of same. I understand that I am financially responsible for any denied or not covered services under my insurance policy, and I am ultimately responsible for payment of my account regardless of my insurance company being billed. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I understand that this office may not wait for my insurance company to reimburse me prior to billing me. I hereby authorize to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as original.

____

Signature of Patient or Guardian (if minor) Date

Mittal Family Healthcare, Inc.

9360 No Name Uno, Suite 240
Gilroy, CA 95020

Phone: (408) 846-8100
Fax: (408) 846-8101

NOTICE OF PRIVACY PRACTICES

(Patient Copy)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Mittal Family Healthcare, Inc., your health information would be kept secure and confidential. The law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send reminders or other information. We may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail the files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither remove nor alter earlier documents, but will add new information.

You have right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Idependence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Gunjan Mittal, MD at 408-846-8100.

This notice goes into effect as of November 1, 2008.

Mittal Family Healthcare, Inc.

9360 No Name Uno, Suite 240
Gilroy, CA 95020

Phone: (408) 846-8100
Fax: (408) 846-8101

ACKNOWLEDGEMENT

I have received a copy of the *Notice of Privacy Practices* for the *Mittal Family Healthcare, Inc.*

Date: __________________

Signature: ______________________________ Print Name: _________________________________

If signing as a parent or guardian, please note the name of the patient: ____________________________

____ .

RECONOCIMIENTO

He recibido una copia del aviso de la *Mittal Family Healthcare, Inc*. *Para Las Prácticas Privadas*.

Fecha: __________________

Firmado: ______________________________ Nombre impreso: ____________________________

Si está firmando como padre o guardián, por favor anote el nombre del paciente: __________________

____.

Mittal Family Healthcare, Inc.

9360 No Name Uno, Suite 240
Gilroy, CA 95020

Phone: (408) 846-8100
Fax: (408) 846-8101

MEDICATION HISTORY AUTHORIZATION

Date: ____________

Patient Name: ________________________________

Date of Birth: ________________________________

I authorize *Mittal Family Healthcare, Inc* to electronically access my past medication history

- ☐ All Prescriptions
- ☐ Only Prescriptions written by Physicians in this office
- ☐ No Prescriptions

Signature: _____________________________

Print name if Signing as Parent or Guardian of the patient ______________________________________