DR. BAHETHI INTERNAL MEDICINE

BHAWNA BAHETHI, M.D. LLC

1600 Crain Hwy South, Ste 502
Glen Burnie, Maryland 21061
Telephone 410.766.8911
Facsimile 410.766.8977

PATIENT REGISTRATION

_____
TODAY'S DATE

Welcome to our office. We are committed to providing you the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PATIENT INFORMATION

_____ _____ _____ _____
LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

SEX: ☐ *MALE* ☐ *FEMALE* _____
GENDER IDENTITY (IF DIFFERENT)

_____ _____ _____ _____
STREET ADDRESS *CITY* *STATE* *ZIP CODE*

_____ _____ _____
CELL PHONE *HOME PHONE* *WORK PHONE*

_____
EMAIL

MARITAL STATUS: ☐ *SINGLE* ☐ *MARRIED* ☐ *WIDOWED* ☐ *DIVORCED* ☐ *SEPARATED*

_____ _____
SOCIAL SECURITY # *RACE*

ETHNICITY: ☐ *HISPANIC* ☐ *NON-HISPANIC* ☐ *OTHER*

_____ _____
PREFERRED PHARMACY *PREFERRED PHARMACY PHONE NUMBER*

_____ _____
EMPLOYER NAME *OCCUPATION*

_____ _____ _____ _____
EMPLOYER ADDRESS *CITY* *STATE* *ZIP CODE*

_____ _____ _____
EMERGENCY CONTACT *PHONE #* *RELATIONSHIP*

_____
WHO MAY WE THANK FOR YOUR REFERRAL?

FINANCIAL INFORMATION

_____ _____ _____
PERSON RESPONSIBLE *DATE OF BIRTH* *RELATIONSHIP*

_____
PRIMARY INSURANCE COMPANY NAME

_____
SECONDARY INSURANCE COMPANY NAME

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Bhawna Bahethi and Associates all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Printed Name of Patient or Representative | *Signature of Patient or Representative*

Insurance Authorization and Financial Agreement

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your insurance carrier.

- We cannot guarantee your insurance company will pay your claims. It is your responsibility to know your coverage based on your insurance plan.
- You are expected to provide complete and accurate information including your full name, address, home/cell telephone number, date of birth, social security number, email address, most recent photo ID and insurance card. Our staff is fully compliant with Health Information Portability and Accountability Act (HIPAA) regulations.
- We require that you pay your co-pay at the time of your appointment. We accept cash, personal checks, Visa, MasterCard and Discover. We will file your claims for services rendered at each office visit.
- We reserve the right to charge the guarantor a **$25.00** fee for missed appointments. There will be a **$35.00** charge for all returned checks.
- Outstanding balances are due within 30 days of service provided. Bhawna Bahethi M.D., LLC reserves the right to reschedule non-emergent patient appointment due to nonpayment.
- Any balance remaining unpaid for 90 days after service was provided shall be forwarded to collection attorney/court. I understand in the event my account is forwarded to collection or court proceedings for nonpayment, I shall be financially responsible for the amount due, collection costs, attorney fees, and all court costs.

Printed Name of Patient or Representative **Relationship to Patient**

Signature of Patient or Representative **Date**