Suresh C. Saraswat, M.D. P.C.
Satyen S. Saraswat, M.D.
611 North Highland Avenue
Murfreesboro, TN 37130

PATIENT REGISTRATION

(PLEASE PRINT)

Requesting to be the patient of: **Suresh C. Saraswat** DATE: _____
NAME: _____ GENDER: _____
SOC. SEC. NUMBER: _____ BIRTHDATE: _____
ADDRESS: _____ EMAIL: _____
CITY: _____ ZIP CODE: _____
TELEPHONE: _____ OCCUPATION: _____
EMPLOYED BY: _____ PHONE: _____
EMPLOYERS ADDRESS: _____
IN CASE OF EMERGENCY: Name and Phone Number_____

Referring Doctor: _____ ***PCP:*** _____

Any Allergies:

ARE YOU: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____
NAME OF SPOUSE: _____ BIRTHDATE: _____
EMPLOYED BY: _____ PHONE: _____
EMPLOYERS ADDRESS: _____

INSURANCE: DO YOU HAVE A MEDICARE ADVANTAGE OR HMO INSURANCE PLAN?

Primary Insurance: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber ID: _____ Group Number: _____
Relationship to Subscriber: _____ Subscriber SSN#: _____

Secondary Insurance: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber ID: _____ Group Number: _____
Relationship to Subscriber: _____ Subscriber SSN#: _____

You may contact me by telephone and leave a message regarding appointments, billing questions, test results, or other health related information.

YES_____ NO_____

I authorize you to discuss appointment matters and health status with the following individuals:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

I authorize you to discuss my billing matters with the following individuals:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Preferred Pharmacy: _____

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)*, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is uses or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Response to the following section is optional but requested by insurance companies

RACE: American Indian or Alaskan Native_____ Caucasian_____ Hispanic_____
African American_____ Pacific Islander_____ Other_____
ETHNICITY: Hispanic or Latino_____ Non-Hispanic or Latino_____
LANGUAGE: English_____ Spanish_____ Korean_____ Hindi_____ Other_____

Patient Name Relationship to Patient

Signature Date

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Please read and initial each section.

Suresh C. Saraswat, M.D., P.C. appreciates the confidence you have shown in choosing us to provide for your healthcare needs. We aim to offer the best quality medical care to all our patients. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Thank you for your understanding and cooperation in this matter.

Co-Pay & Deductible Policy

1. You are responsible for payment of any co-pays/coinsurance/deductible as determined by your insurance carrier. **We expect these payments at the time of service**. Payment of all co-pays/coinsurance/deductibles is expected at the time the service is rendered for the patient.
2. Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know their coverage and benefits**. You are responsible for any amounts not covered by your insurance carrier. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your remaining balance.
3. I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

I have read the above policy regarding my financial responsibility to Suresh C. Saraswat, M.D., P.C. for providing medical services to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Suresh C. Saraswat, M.D., P.C. the full amount of the bill incurred by the above named patient with the agreement that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

Patient Name Date

Signature

***If you cannot make full payment at the time of service you will need to meet with the insurance manager to see about other arrangements. ***