PATIENT REGISTRATION

DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ SS#: ____-____-_____

CITY: _____ STATE: ____ ZIP: _____ DL#: _____

HOME PHONE: _____ CELL: _____ WK: _____

PATIENTS EMPLOYER: _____

MARITAL STATUS: _____ EMAIL ADDRESS: _____

SPOUSE'S NAME: _____ SPOUSE'S SSN: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK #: _____

NEAREST CONTACT PERSON/PHONE #: _____

PHARMACY NAME: _____ PHARMACY NUMBER: _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Samuel A. Tyuluman, M.D., P.A., to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, Managed Care organizations, IPA's Medicare/Medicaid or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. I understand that Samuel A. Tyuluman M.D. will utilize HIPPA guidelines regarding the privacy of my information. I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof. Signature below confirms understanding financial responsibility and authorization to release patient information statements.

NAME OF INSURANCE COMPANY: _____

INSURED'S NAME: _____ DOB: _____

INSURANCE ID: _____ GROUP: _____

SIGNATURE: _____

OUR FINANCIAL POLICY

We ask that ALL patients read and sign our Financial Policy prior to seeing the doctor. If you have any questions or concerns, please ask our front office staff. For your convenience, co-payments and deductibles are collected at the beginning of your visit. We accept cash, Visa, Mastercard, Amex, and Discover. **WE DO NOT ACCEPT CHECKS.** We will file your visit with your primary insurance for reimbursement, **WE DO NOT FILE SECONDARY INSURANCE.** It is your responsibility to bring your current insurance card with correct, up-to-date information at the time of your visit. Remember, it is your insurance policy and it is your responsibility to understand your benefits and which physicians and healthcare facilities you may use. **BCBS HMO PATIENTS ONLY-You MUST have a referral from your primary care physician for us to see you.** Those services not covered or denied by your insurance will be patient responsibility.

CANCELLATION AND MISSED APPOINTMENTS:

If you need to cancel your appointment, we kindly request that you allow at least 24-hour notice. If we do not receive a 24-hour notice, there will be a $50 Cancel/No-Show fee billed. Patients with multiple cancellations and or missed appointments may be discharged from our practice.

I have read and understand the financial policy and agree to the terms. I understand and agree that such terms may be amended in the future by the practice.

Signature of responsible party: _____

Date: _____

Credit Card Save on File

For your convenience, we kindly request that you leave a credit card on file which may be used to reduce your remaining balance after insurance pays. Please complete and sign the following:

_____ I authorize Dr. Samuel Tyuluman to bill my insurance for the services rendered today. Upon receipt of payment from my insurance company, I authorize Dr. Samuel Tyuluman to charge the below listed credit card in the amount of the unpaid balance.

_____ I understand that hormonal procedures and injections are not billed to my insurance. Should there be a remaining balance on hormonal services, I authorize Medami Labs to charge the below listed credit card in the amount of the remaining unpaid balance.

_____ An email will be sent to notify me on the additional charge to my credit card. **WE WILL NOT NOTIFY YOU BEFORE CHARGING YOUR CARD.**

Patient Name: _____ DOB: _____

Card Holder
Address:_____

Card Holder Email Address: _____

Name as it appears on credit card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code on Back: _____

Credit Care Authorizing Signature: _____

Date: _____

OFFICE USE ONLY:

Employee Initials: _____ Date Saved: _____

Notice of Patient Privacy/Patient Consent Form

I understand that as a part of my healthcare, Samuel A. Tyuluman, M.D., P.A. (the physician) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for further care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Notice of Privacy Practices provides specific information and complete description of how my Protected Health Information may be used and disclosed. Protected Health Information is detailed in Section 1171 of Part C of Subtitle F of Public Law 104-191 (August 21, 1996): Health Insurance Portability and Accountability Act of 1996. Protected Health Information (PHI) is defined as health information and individually identifiable health information. I understand that the physician reserves the right to change the Notice of Privacy Practices. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment or healthcare operations and that the physician is not required to agree to the restrictions requested. I give permission to use facsimile and the password protected private email provided below for the communication if Protected Health Information. Once transmitted to the emailed specified below, I am responsible for the security of this information. I may revoke this consent at any time in writing except to the extent that the physician has already acted in reliance on my prior consent. This consent is valid until revoked by me in writing. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. For more information about this notice or our privacy practices and policies, please contact the office.

Secure Email Address: _____

NOTE: The physician must obtain your written authorization to use your Protected Health Information for any purpose other than treatment or billing. If you want the physician to have access to disclose your private health information to your spouse or any other person during your treatment, please sign below.

I agree to allow Samuel A. Tyuluman, M.D., P.A. to disclose my protected health information (including date/time of appointments) to:

__Spouse: _____ Tel:_____

__Family Member:_____ Tel:_____

__ Other: _____ Tel:_____

__ Myself only, no other family member

This does not serve as a release of medical records. I further understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that I have access to or have reviewed the Notice of Privacy Practices for the following medical practice. Samuel A. Tyuluman M.D. 9301 N. Central Expy #475 Dallas, TX 75231

A copy of this agreement may be used with the same effectiveness as an original.

Print Name of Patient/Legal Representative: _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Health information means any information, whether oral or recorded in any form or medium, that: (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of any individual, or the past, present, or future payment for the provision of health care to an individual. Individually identifiable health information is information that is a subset of health information, including demographic information collected form an individual: (1) That is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.