

# PRASUNA SAJJA, M.D., P.A.

707, S Fry Rd, Suite 394 • Phone: (281) 647-9355 • Fax: (281) 647-9357

## 1. Patient Information

Patient Name:	Last	MI	First	Sex: M / F	Birth Date:
Address:	Apt / Suite #:				
City:	State:	Zip:	SSN / Patient #:		
Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for ___ Yrs					
How did you hear about us?					
<input type="checkbox"/> Friends/Family		<input type="checkbox"/> Phone Book		<input type="checkbox"/> Flyer/Ad	
<input type="checkbox"/> Health Insurance		<input type="checkbox"/> Internet		<input type="checkbox"/> Physician referral	
<input type="checkbox"/> Christus Patient Magazine		<input type="checkbox"/> Katy Magazine		<input type="checkbox"/> Living Magazine	
<input type="checkbox"/> Welcoming Neighbor					

## 2. Insurance Information

Primary Insurance:	Guarantor:	Guarantor DOB:
Secondary Insurance:	Guarantor:	Guarantor DOB:
<p>I certify that the above patient has insurance coverage with the above named insurance company(ies) and I assign directly to clinic or the treating physician all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The clinic 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. I authorize the release of any health care information necessary to process my insurance claim(s) as requested by my insurance company(ies). I agree that any additional information requests for information from my insurance company regarding coverage or any related questions will be answered by me in a timely manner or the balance due will become my responsibility. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.</p>		

## 3. Contact Information

In a continuing effort to enforce privacy regarding our patient's medical information, we are requesting that you provide a designated phone number where messages can be left. Our preference is always to speak with you, but we do understand that you will not always be available to be contacted. Please indicate below where we can leave a message and you are able to retrieve it.

Print your phone # below	Voice mail options	Preference	Special Instructions
Home:	<input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Appointment reminders <input type="checkbox"/> OK to leave message with detailed / healthcare info	1 2 3	
Work:	<input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Appointment reminders <input type="checkbox"/> OK to leave message with detailed / healthcare info	1 2 3	
Mobile:	<input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Appointment reminders <input type="checkbox"/> OK to leave message with detailed / healthcare info	1 2 3	

## 4. Emergency Contact

Name of Authorized Person:	Relationship to Patient:
Phone # 1:	Phone # 2:

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### 5. Release of medical information

\_\_\_\_\_ I understand that requests for medical information release will require specific authorization prior to the disclosure of any information.

\_\_\_\_\_ I hereby give explicit permission to the clinic to release my medical records, disclose and discuss any information related to medical condition(s) to the treating physician **during a medical emergency**. I understand that the duration of this authorization is indefinite unless otherwise revoked in writing.

### 6. Acknowledgement

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

\_\_\_\_\_ **Payment Policy:** I understand that I am financially responsible for all charges whether or not paid by insurance. I have read and understand the payment policy of the practice, and I agree to abide by its terms. I also understand and agree that such terms may be amended by the clinic from time to time.

\_\_\_\_\_ **Patient Responsibility:** I have read and understand the Clinic's Patient Rights and Responsibilities. I understand that when my physician orders lab work or radiological procedures, it is my responsibility to follow through and have the ordered test performed. I understand that if I have not received a call or letter from this clinic regarding results of those tests, it is my responsibility to call the office for my results about four weeks after the tests were performed. It is my responsibility to have an accurate address and/or phone number on file in order to be contacted regarding lab or radiological results.

\_\_\_\_\_ **Privacy Practices:** I have read and understand the clinic's Notice of Privacy Practices and give permission to the clinic and the treating physician to use and disclose my medical information in accordance with that Notice.

### 7. Appointments

Keeping your busy lifestyle in mind, we offer extended office hours on certain weekdays (currently Thursdays from 5:00 pm to 7:00pm) and on Saturday mornings. We kindly request that you give us at least 24 hours notice prior to cancelling or rescheduling all your appointments.

\_\_\_\_\_ I acknowledge that I will be charged a fee of \$25 (billed directly to me) for any "no shows" or cancellations made without a 24 hour notice, for appointments made during the extended hours.

### 8. Signature

I hereby give consent to the medical staff of the above clinic for any medical examination and medical or surgical treatment as considered appropriate by the physician.

I hereby certify that all information provided by me in this form and the attached copy of insurance identification card(s) is true, accurate, valid, and current. I agree to provide updated and/or corrected information within 5 business days of request or upon presentation for my next office visit, whichever comes first.

If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this form must be signed by a parent, guardian, or legal representative who has the authority to act on the minor Patient's behalf. By signing this form for someone else, you as the parent, guardian, or legal representative, warrant that you have the legal authority to act on the Patient's behalf.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by someone other than patient, Print your name and state your legal relationship to the patient

Preferred Pharmacy Name / Location: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_