Padma Sripada MD, Columbia Internal Medicine & Laser Aesthetics
2500 Pond View, Suite 202 Castleton on Hudson, NY 12033 Phone: 518-391-2889 Fax: 888-990-1152

Date: …………………………

Patient Registration Form

First Name ………………………………………… Last Name..…………………………………..………Sex: M F

Date of Birth …………………………………….. Birth Place ………………………………..............................

Street address .. …. ……………………………… Town …………………………………ZIP Code………………

E-mail ID……...…………………………………….. Home # …………………………………….…. ………………

Work# …………………………………………………Cell# ……………………………………………………..............

Social Security #...Occupation………………………………………………………..

Employer Name/Address……………………………………………………………………………………………

Pharmacy Name ……………………………………..Phone#…………………………………………………………….

Marital Status: Single Married Divorced Widow

Spouse's Name ……………………………………………Date of Birth……………… Number of Children:………

Significant other (Name) ……………………………………………………………………………………………

Spouse's Employer Name and Phone# …………………..……………….………………………………......................

Emergency Contact Name: ….. ………………………….………………………………… Ph# ....

Name of the Insured person………………………………………………DOB ………………………………………………..

Name of Insurance …………………………………………………… ID# ………………………………………………

How did you know about our practice? Family/Friends Internet Insurance Advertiser newspaper

Other (Please specify) ……………………………………………………………………………………………

What did you like about our practice……..…………………………………………………………………………

Our Office Policies

- All refills will be given at the time off an office visit only. Medications will not be called between office visits.
- Missing an appointment without notice (No-show) or cancellation with less than 24-hour notice may incur surcharge up to $75. Multiple No-shows will lead to discharge from the practice.
- Co-pay not paid at the time of service may incur a surcharge of $5.
- Balances on accounts not paid in a timely manner may be turned over to a collection agency. There will be a charge for all costs associated with this action including the collection fees.
- It is the patient's responsibility to call their insurance company to make sure our physician is in their network to avoid any additional charges or fees.

Medical Information

Chief Complaint. ....

Medications/Dosage

Present...

Past year..

Are you Allergic to or intolerant of any drugs? If yes, please list the drugs and your reaction

Operations done with dates ....

Other Major Illnesses and Hospitalizations ....

Do you smoke? ....Packs/Day..........Did you smoke? .... Date stopped? ....

How often do you have a drink (Beer, Wine, Liquor?) ....

Have you ever had any problems related to alcohol? ....

Medical history

If there is any history of following in either yourself or immediate family, please circle below

Alcoholism	Chemical dependency	High Cholesterol	Pacemaker/ Defibrillator
Anemia	Clotting disorder	High blood pressure	Polycystic ovaries
Anorexia	Connective tissue	HIV/AIDS	Psychiatric disorder
Arthritis	Diabetes	Kidney disease	Pigmentation disorder
Asthma	Eating disorder	Lung disorder/ Oxygen therapy	Seizures
Autoimmune disease	Epilepsy	Mental illness	Skin lesion
Bleeding disorder	Fibromyalgia	Migraines	Stroke
Breast pump	Heart Attack/ Coronary artery disease	Multiple sclerosis	Tuberculosis
Cancer	Hepatitis A, B or C	Neuromuscular disorder	
Chronic Fatigue	Herpes/ Cold sores (oral or genital)	Osteoporosis	

Please provide additional information (if any) on any of the above:

Mention any history not listed above:

Allergies

List any medication/ food/ environmental/ shellfish allergies

Are you allergic to Latex? No Yes

Are you allergic to Iodine? No Yes

Any other allergies? (Please mention) ……………………………………………………………….

Medications

Please list medications or supplements (aspirin, herbal medicine, fish oil, vitamins etc.) you are taking

And /or any of the following:

Accutane (current or within past 6 mths)	Blood thinner (Aspirin, NSAIDS)
Coumadin (Xareloto, Pradaxa)	Hydroquinone
HCG injections	HCH injections
Male hormone therapy (injections, gel)	Oral/ implantable contraception
Vitamin A (Retin-A, Renova, Differin)	Weight loss (Adipex, Diethylpropion)

Other skin care medications/ tropical agents including OTC)

Aesthetics Visit: Nature of your visit

Botox	Hydrafacial	Laser hair removal	Photoacial
Pigment removal	Rosacea	Skin rejuvenation	Vascular lesions

Privacy

Do we have your permission to:

Leave a message at your place of employment?	Yes	N o
Send your medical information to your personal E-mail?	Yes	No
Discuss your medical condition with a member of your household?	Yes	No

If yes, Name:…..Relationship:.........................

- We encourage you to register for secure e-mail through our website: doctorpadma.com to receive our messages, test reports and more.

Consent to treat and assignment of benefits/ authorization to release information:

I consent to treatment necessary for the care of the patient name on this document. I authorized Columbia Internal Medicine LLC to submit claims to my insurance carrier and release any information needed for the processing of claims related to medical services rendered. I allow for release of my personal health information according to HIPPA law for the treatment, payment and operations. I authorized assignment of benefits for physician and lab services to Columbia Internal Medicine LLC. A copy of the signature is as valid as the original. I understand that I am financially responsible for any services not covered by my insurance carriers. The information I have provided on this registration form is true to the best of my knowledge. I acknowledge that I have received, read and understand the financial and office policies of Columbia Internal Medicine.

- **Patient (Please print)** ....
- **Signature**...**Date**.....................................
- Parent/Guardian (Please print)..
- Signature .... Date...

Patient -Centered Medical Home
The Provider- Patient Agreement

Synopsis

The goal of Columbia Internal Medicine is to provide patient centered care to all of its patients. Patient centered care is a means for the provider. patient and families work together with the goal of providing quality healthcare to the patient. This will be achieved through patient and family interaction whereby the needs and preferences of the patient are communicated to Columbia Internal Medicine. Columbia Internal Medicine in turn will listen to these needs and then focus on their education and training to ensure better healthcare results.

Objectives

Columbia Internal Medicine and the patient will achieve this patient centered care based on the following mutually agreed upon terms:

Columbia Internal Medicine will provide quality healthcare to the best of their ability and knowledge, in a safe environment.

Patients and their families have the ability to ask questions and voice concerns through an open channel of communication with our providers.

The patient/parent is honest in the history of symptoms. Columbia Internal Medicine's provider is open and honest in relating the diagnosis and related treatment. It is important for the patient/parent to disclose all the symptoms or medical problems at the time of treatment.

The patient/parent is compliant in following agreed upon treatment plans. Columbia Internal Medicine will provide clear and understandable instructions.

Columbia Internal Medicine will provide patients with sufficient time during their office visit to ensure the medical problems are s understood and the treatment protocol is thoroughly explained. Both the patient/parent and provider shall respect one another's time.

The patient/parent will pay for their share of the provider services rendered not covered by their insurance at the time of the office visit. It is the patient/parent responsibility to know their insurance benefits.

Columbia Internal Medicine provides reasonable office hours and has instructions for after hour emergencies through their office telephone number, which includes access to a physician by phone 24/7.

Columbia Internal Medicine offers same day appointments for acute care and allots appropriate time frames for follow up, preventative care and disease management appointments.

Columbia Internal Medicine may refer patients to a specialist or suggest certain tests/procedures that are not done in the office. Instructions will be provided for these instances. It is the patient/parent responsibility to find out if the specialist is covered by their insurance.

Columbia Internal Medicine is not responsible for costs incurred by the patient for specialty care or tests/procedures recommended by our providers.

Columbia Internal Medicine will facilitate the referral process. However, it is the responsibility of the patient/parent to follow up with the referral and understand the insurance coverage for the specific referral.

Columbia Internal Medicine will provide results of lab/x-ray tests by calling the patient/parent. The patient/parent should call the office if not notified about test results in an appropriate time frame.

The patient/parent shall do their best to participate in healthy habits and lifestyles.

Columbia Internal Medicine may provide educational resources. The patient/parent utilizes these resources and asks questions if needed.

The patient/parent will keep their appointments. Otherwise a missed appointment fee will be applied.
The patient/parent shall arrive on time for their scheduled appointment. Columbia Internal Medicine in turn will work to stay on schedule.

Columbia Internal Medicine will respect the patient/parent individuality. We will not make judgments based on race, religion, gender, gender identity, age or disability.

Columbia Internal Medicine will respect patient/parent privacy. Medical information will not be shared with anyone unless it is vital for ongoing care, you give us permission, or it is required by law or court order.

Columbia Internal Medicine participates in electronic prescription programs with affiliated pharmacies. Prescriptions are sent to your specified pharmacy electronically; otherwise, a printed prescription will be provided.

This agreement describing Columbia Internal Medicine optimal provider-patient relationship has been given to and has been received by a patient/parent by his or her provider today.

- **Patient (Signature)** ....**Date**..
- **Name** (Print)...

Provider.. **Date** ....

HIPPA Consent Form

I give consent to the above practice to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations, like quality reviews. I have been informed that I may review the practice's Notice of Privacy Practice (for a more complete description of uses and disclosers) before signing this consent. I understand that I have the right to request a restriction of how my processed health information used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s). Ialso understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

- **Signature:** .... **Date:** ....

If signed by patient representative, state relationship to patient: ....

Authorization for Disclosure of Health Information

Date .... Patient's name... DOB ....

Street address/State/Zip code ....

Purpose or need for the disclosure Continued care Coordination of care

My previous provider was

Name ………………………………………………………………………………………………………

Address ……………………………………………………………………………………………………..

Ph# …..……………………… Fax# ……………………………………………..…………………………..

I hereby authorize above provider to release my medical information to the following provider

Padma Sripada MD

Columbia Internal Medicine 2500 Pond View Ste # 202, Castleton NY

12033 Ph # 518-391-2889 Fax# 518-391-2304

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrolment in a health plan or eligibility of benefits. However information will not be released to the above recipient without my signature. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I have the right to revoke this authorization by written notice to the Healthcare provider listed above. I understand that the actions taken in reliance of this authorization cannot be reversed and my revocation will not affect those actions.

I understand that my record may include information relating to drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (STD),AIDS related complex (ARC) and /or human immunodeficiency virus (HIV) and immunization record.

Fees: I understand that there may be costs associated with this request in compliance with the state laws. This authorization will expire on (Date)…………………….... or upon the event of ……….…….. (if no date is specified, this authorization will expire in six months from the date of signature.)

………………………………………………………………… ……………………………

- **Signature of the patient or authorized patient representative (*)** **Date**

(*) If signed by a patient’s representative, the representative's is authorized to act as follows (circle applicable)

Parent	Legal guardian	Healthcare proxy	Power of attorney
Administrator	Executor of estate	Next of kin	Beneficiary

Patient Treatment Waiver

Date: …………………………
(A)
I (Name of patient) ,……………………………………………………… DOB………………………..have a valid health insurance policy. I am seeking consultation/treatment from Dr. Padma Sripada. If the health insurance company denies payment for my visits, I agree to pay the due charges in full including applicable collection charges as explained below.

I specifically agree to reimburse the fees of any collection agency which may be based on a percentage of maximum 33%R of the debt an d all costs, expenses including reasonable attorney fees incurred by the practice in such collection efforts.

- **Signature of patient ……………………………………………………………………………………………**

  Witness (Signature) Witness name…………………………… ……...

(B) For patients under the age of 18 and patients with Visitors' insurance

I agree to all the clauses under (A) above

- **Signature of Parent/Guardian/ Local guarantor ……………………………………………………………..**
- **Name (Print) ...…………………………………..……………………………………………………………**

Address………………………………………………………………………………………………………..

Phone # (Home)…………………………………..Phone# (Cell) ………………………………………………………

Witnessed by: (Signature) ……………………………………………………………………………………

Name (Print)……………………………………………………………………………… ……...

Aesthetics Authorization

Patient is responsible for all the charges incurred. At this time, the office will not file any claim on the insurance. Payment in full is due at the time of service.

I……………………………………………., have fully read and understand the statement policy. I authorize the aestheticians of Dr Padma Sripada to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician/physician assistant/ Nurse practitioner and I consent to care by such providers. I understand these services are voluntary and that I have the right to refuse these services.

- **Signature ……………………………………………………………… Date ……………………………………..**

* Please allow 24 hour notice in the event of appointment cancellation. Clients with more than two no-shows or late for appointments will be charged a fee of $100 for future appointments.

I authorize the facility to release the information to (please check all that apply and provide first and last names and phone numbers.

Spouse Children

Others No one

- **Signature ……………………………………………………………. Date …………………………….**

Furthermore I consent to the procedure agreed with the providers at Dr. Padma's Aesthetics

Botox **Laser** **Hydrafacial** **Other** (Specify)

- **Signature ………………………………………………………….. Date …………………………**

- Permission for taking aesthetics related pictures without my identity Granted Declined