Rupen Joshi, M.D., L.L.C.
333 Whitesport Dr. Ste 305
Huntsville, AL 35801
Phone: 256-880-1222 Fax: 256-880-2666

Today's Date:__________________ Birthdate:______________ SS#:__________________
Physician Referred By:____

PERSONAL INFORMATION

Patient's Name:____ M F
Name you wish to be called:______________________ Marital Status: M D S W
Street Address: ____
City: ____ St:_________ Zip:______________
Employer/School:____
Employer/Occupation:____

TELEPHONE

Home Phone #:____
Work Phone #:____
Mobile Phone #:____
Can we leave a message on your answering machine? ☐ Yes ☐ No
Can we email you? ☐ No ☐ Yes Email address:_______________________________

SPOUSE

Spouse's Name:_____________________________ Phone #:______________________
Souse's Employer:____

RELEASE INFORMATION

I authorize release of information (including facsimile transmission) relative to my medical records and /or lab results to: ☐ My Self ☐ My Souse
☐ My Child ☐ Legal Ward______________ Other______________

For Office Use	I revoke the above authorization because ________________________ ________________________ Date:___________________ Initials:___________

EMERGENCY *In the event of an emergency please contact:*

Name:_______________________________________ Relationship:___________________
Work Phone #:________________________________ Home Phone#:___________________

INSURANCE INFORMATION

Primary Insurance *(Please provide insurance card for us to copy)*

Plan Name:_______________ ID #:____________________________ Group #:__________

Name of Insured:____________________________________ Co-pay: $_______________

Relationship to patient:____

Insured's Birthdate:_____________________ Insured's SS#:__________________________

Secondary Insurance *(Please provide insurance card for us to copy)*

Plan Name:_______________ ID #:____________________________ Group #:__________

Name of Insured:_____________________________ Co-pay: $______________________

Relationship to patient:____

Insured's Birthdate:_____________________ Insured's SS#:__________________________

PERSON TO BILL *(Who will pay for services not covered by insurance?)*

Name:____ SS#:______________________

Relationship to Patient:______________________________ DOB:______________

Street Address:____

City:____________________________ St:__________ Zip:________________

Work Phone #:_________________________ Home Phone #:_________________

Note: We accept personal checks, Visa, Master Card, Discover, and/or cash. Patient balances over 30 days old are subject to a 1 ½ % monthly service charge. (18% annually)

I have read and understand the practice policies regarding patient expectations.

X____

Signature **Date**

AUTHORIZATION AND RELEASE

I hereby authorize Rupen Joshi, M.D., L.L.C. to release any information regarding services rendered to me or my child (including diagnosis, record of treatment or examination) to third party payers in consideration of payment for my care or to other healthcare practitioners involved in providing my/my child's care. I authorize and request my insurance company/Medicare/Medicaid to pay benefits otherwise payable to me directly to the physicians/physician group. I understand that my insurance carrier/Medicare/Medicaid/benefit provider may pay less than the actual bill for the services; and I agree that I am responsible for the payment of all services rendered regardless of the insurance coverage. Should this account be turned over to collections, I am responsible for all the cost of collections as well as attorney fees.

Signature of patient (or parent if minor):___________________________ Date:______________

NOTICE OF PRIVACY ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to other unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how you access your information. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____ ____________________

Patient or legally authorized individual signature **Date**

For office Use	☐ Good faith attempt has been made to provide the patient with our Notice of of Privacy Practices. ____ Employee Signature Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

Due to Federal Law changes we need additional information on our patients now. Please fill out the following information.

What Pharmacy do you use? Pharmacy Name: ______________________________

Street: ______________________________

Preferred Language: __________________

Race (Select One)

____ White

____ Black or African American

____ Asian

____ American Indian/ Alaska Native

____ Hawaiian/ Pacific Islander

Other Race: _________________

____ Unknown

Ethnicity (Select One)

____ Hispanic or Latino

____ Non-Hispanic or Non-Latino

____ Unknown

Best way to reach you:

Home #: __________________

Work #: __________________

Cell #: ___________________

We also are now able to web enable you to our computer system, this is where you can see your lab results, message the nurse for refills, ask any questions that you have, and appointment reminders are sent to your email accounts.

Email: _____________________________________

Would you like for us to set you up for this system? _______Yes _______No

If you checked Yes on the web enable Please make sure we have the correct Email for you!

Thank you!

Rupen Joshi, M.D., L.L.C.

333 Whitesport Dr. Ste 305
Huntsville, AL 35801
Phone: 256-880-1222 Fax: 256-880-2666

Medical / Family / Social History

Name:______________________________ Date:____________________
SS#:______________________________ Date of Birth:______________

Chief Complaint

Why are you seeing the doctor today?

____
____
____
____

Current problem is the result of:
○ Illness ○ Work Accident ○ Car Accident ○ Injury Other:__________

When did you first notice the symptoms?______________________________

Past Medical History

Surgeries / Hospitalizations	Year	Complications

Medical Problems:
Please list all medical problems / illnesses for which you are currently being treated:

____
____
____
____

Medication Name	Dose/Strength	How Often	How Long	Side Effects

Allergies: Medications:____
Food / Environmental:__________________________________
Other:____

Review of Symptoms

Are you currently having or have you had problems with: Please Circle (If yes, please describe)

Eyes	No	Yes	________________
Ears, Nose, Throat	No	Yes	________________
Respiratory (Lung/Breathing)	No	Yes	________________
Gastrointestinal	No	Yes	________________
Cardiovascular (heart)	No	Yes	________________
Urological Problems (Bladder)	No	Yes	________________
Diabetes	No	Yes	________________
High Blood Pressure	No	Yes	________________
Endocrine (Thyroid)	No	Yes	________________
Hematologic (Bleeding)	No	Yes	________________
Numbness/Tingling	No	Yes	________________
Psychological Problems	No	Yes	________________
Neurological Problems	No	Yes	________________
Psychiatric Problems	No	Yes	________________
Allergic/Immunologic	No	Yes	________________
Musculoskeletal	No	Yes	________________
Integumentary (Skin)	No	Yes	________________

Family History (Please Circle)

Single Married Separated Divorced Widowed

Mom: Living or Deceased age____________________

Dad: Living or Deceased age____________________

Brothers: Living or Deceased ages________________

Sisters: Living or Deceased ages__________________

Children: Living or Deceased ages_______________

Has anyone in your immediate family, other than yourself, been diagnosed with the following diseases: **PLEASE CIRCLE** who has/had history of medical conditions?

Cancer:	Mom	Dad	Grandparents	Siblings	Children
Heart Disease:	Mom	Dad	Grandparents	Siblings	Children
High Blood Pressure:	Mom	Dad	Grandparents	Siblings	Children
Diabetes:	Mom	Dad	Grandparents	Siblings	Children
Bleeding Disorder:	Mom	Dad	Grandparents	Siblings	Children

Other (specify): ____

Social History

Please Check: Employed (occupation)______________________________

Student

Exercise: Daily Weekly Monthly Rarely Never

What type of exercise? ______________________________

Are you on a special diet? No Yes: Describe______________________

History of substance abuse? No Yes: What ______________________

Current Smoker? No Yes: Packs per day__________ for ______yrs

Previously smoked? No Yes: Year Quit ______________

Drink Alcohol? No Yes: Type __________Frequency ______

Reviewed By: ________________M.D. Date:________________

INDIVIDUAL PATIENT'S AUTHORIZATION

Rupen Joshi, M.D., L.L.C.
333 Whitesport Dr., Ste. 305
Huntsville, AL 35801
Phone: 256-880-1222

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.

Name:____________________ DOB:______________Social Security #:_________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations-and that the organization is not required to agree to the restrictions requested.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.

I understand that I may revoke this authorization at any time giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has the right to contest my claims under the insurance policy.

Specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.:

____

The information will be used or disclosed for the following purpose ("at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):

____

I request the following restrictions to the use or disclosure of my health information:

____

****Please list names of non-medical persons with whom we may discuss your medical information:**

____

Expiration date or event that relates to the individual or the purpose of the use or disclosure:

____

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Individual patient's Signature

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

X________________________ ____________________ ____________________

Signature of patient or Legal Representative Date Witness Signature

______ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health information may be used and disclosed, and how I may access that information.

X________________________ ____________________ ____________________

Signature of Patient or Legal Representative Date Witness Signature

Rupen Joshi, M.D., L.L.C.

333 Whitesport Dr. Ste 305
Huntsville, AL 35801
Phone: 256-880-1222 Fax: 256-880-2666

Authorization for release of Medical Information

Release To:
Rupen Joshi, M.D.
333 Whitesport Dr. Suite 305
Huntsville, AL 35801

Release From: (Whom do we need to get your records from?)

____

____

____

I hereby authorize the release of my medical records, including but not limited to medical history, physical conditions, x-rays, lab studies, and/or treatment of the psychiatric and substance abuse records to the above name and address. Photo static copies of this authorization carry the same authority as the original.

Patient's Full Name (Print):________________________________

Date of Birth: __________________ Social Security#:__________________

____________________________________**Date:**__________________
Patient or Legal Guardian Signature

Witnessed By:_______________________**Date:**__________________

Rupen Joshi, MD LLC

Office Policies

1. (NEW POLICY) CO-PAYS, DEDUCTIBLES, AND BALANCES WILL BE COLLECTED BEFORE YOU CAN SEE THE DOCTOR. **If you have a High Deductible or an unmet deductible, a payment of $100 will have to be paid upfront at the time of service.** Patients will also be responsible for any other amount that the insurance puts toward the deductible above the $100. Patients will be responsible for any tests/ injections that insurance does not pay for.

2. **(NEW POLICY) If you do not have your co-pay and/or your deductible payment at the time of service, your appointment will be rescheduled for when you can pay it. **(NO EXCEPTIONS!)**

3. ***(NEW POLICY) If unable to keep your scheduled appointment, please let us know **no less than 24 hrs. Prior** to your appt. If you **NO SHOW/ Cancel or Reschedule** your appt. less than 24hrs of the appt. time you will be charged a **$25 FEE.**

4. There will be a $25 CHARGE on all forms you request the doctor to fill out.

5. A $25 service charge will be assessed on all returned checks.

6. You must have a copy of your **All** insurance cards; we will no longer accept any letters from the insurance company as proof of coverage. Your insurance will be verified at every visit.

7. Please ALLOW 24 TO 48 HOURS FOR REFILLS ON ALL MEDICATIONS. Prescriptions called/faxed in over the weekend will not be sent to the pharmacy until the next business day.

8. Referrals/Tests will be called in by our nurse WITHIN 48 HOURS AFTER YOUR APPOINTMENT. Please call the nurse if you have not heard from her AFTER 48 hours.

9. We will not release any medical records or perform any other services, i.e. Refills on prescription, or filling out forms until your BALANCE IS PAID IN FULL.

10. Please let our receptionist know if you have any CHANGES IN YOUR ADDRESS, PHONE NUMBER, OR INSURANCE as soon as possible. Please call as soon as you know about the changes; please do not wait until your next appointment.

11. Patients are responsible for any changes in their Insurance policies, if your insurance delays payment or denies payment for any reason after 90 days; it will be the patient's responsibility to pay. If you have questions regarding a payment or lack of payment by your Ins. Company, that our office has billed you for, **Please call your insurance company first**; as they will have more info then we do and will be able to answer your questions.

12. **Also we give you a courtesy call to Remind you of your appointment; however you are responsible for keeping up with your appt. date and time.**

Print Name:_____________________________

Signature:_______________________________ **Date:**_________________

Rupen Joshi, M.D., L.L.C.

Patient Health Questionnaire

Patient Name:______________________________DOB:________________________Date:_________________

General/Constitutional

Weight loss	O Yes	O No
Weight gain	O Yes	O No
Loss of appetite	O Yes	O No

ENT

Nose bleeds	O Yes	O No
Ringing in ears	O Yes	O No
Hearing loss	O Yes	O No
Sore throat	O Yes	O No
Eye pain	O Yes	O No
Blurred vision	O Yes	O No

Cardiovascular

Shortness of breath	O Yes	O No
Chronic cough	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No

Gastrointestinal

Nausea	O Yes	O No
Vomiting	O Yes	O No
Abdominal pain	O Yes	O No
Change in bowel habits	O Yes	O No

Hematology

Anemia	O Yes	O No
Easy bleeding	O Yes	O No

Genitourinary

Urinary incontinence	O Yes	O No
Urinary urgency	O Yes	O No
Urinary frequency	O Yes	O No

Musculoskeletal

Joint pain	O Yes	O No
Joint stiffness	O Yes	O No
Joint swelling	O Yes	O No

Endocrine

Excessive thirst	O Yes	O No
Excessive sweating	O Yes	O No

Neurologic

Headache	O Yes	O No
Tingling/numbness	O Yes	O No
Memory loss	O Yes	O No
Confusion	O Yes	O No

Psychiatric

Depression	O Yes	O No
Anxiety	O Yes	O No

Surgical History

O None	O Cataract	O Heart Stent	O Pacemaker, cardiac
O Tubal Ligation	O Hysterectomy	O Mastectomy	O Appendectomy
O Prostatectomy	O Thyroidectomy	O Gallbladder	O Knee replacement
O Back surgery	O Hip surgery		

Rupen Joshi, M.D., L.L.C.

Patient Health Questionnaire

Past Medical History

O None O Arthritis O Diabetes O Cancer O High Cholesterol
O COPD O Stroke O Hypertension O Atrial Fibrillation O CHF
O Coronary Artery Disease O Kidney Disease

Family History- Please mark None or mark those that apply to you:

Mother: O None O Diabetes O High Cholesterol O Heart disease O Heart attack
O PVD O Hypertension O Cancer O Stroke

Father: O None O Diabetes O High Cholesterol O Heart disease O Heart attack
O PVD O Hypertension O Cancer O Stroke

Grandparents: O None O Diabetes O High Cholesterol O Stroke O PVD
O Heart disease O Heart attack O Hypertension O Cancer

Social History- Please mark the answers that apply to you:

Marital Status: O Married O Single O Divorced O Widowed

Occupation: O Full-time O Part-time O Retired O Unemployed O Disabled

Exercise: O Never O Daily O 1-2 x weekly O 3-4 x weekly

Caffeine: O None O Daily O Occasionally
If yes: O 1 cup/drink daily O 2-3 cups/drinks daily O 4 or more cups/drinks daily

Smoking: O Yes O No O Trying to quit O Previous smoker
If yes, cigarette daily uses: O ½ pack O 1 pack O 2 packs O More than 2 packs

Alcohol: O Never O Daily O Social Drinker O Trying to Quit
O Recovering Alcoholic