**Patient Registration**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_ Billing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status: S M W Sep D

Race- (Please circle) White, Black, Hispanic, Asian, American Indian, Other\_\_\_\_\_\_\_\_ Language\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of Emergency, who should we contact:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel#: \_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information: I am retired\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_SSN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Advance Medical Directive (please circle) YES OR NO

(Includes: medical power of attorney, living will, proxy, instruction directive)

Office Policy and Patient responsibility

**I am responsible for understanding my rights and responsibilities under my medical insurance policy, for understanding what procedures are covered or not, and for understanding the general policies of my insurance contract as they pertain to me. This includes knowing if a referral is required to see a specialist and what lab and/or radiology center I must use.**

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

**Your Primary Care Doctor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Provider** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe reason for today’s visit**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Present Medications: |
|   |
|   |
|   |
|   |
|   |
|   |
|   |
| Allergies to medications/Allergies  |
|   |
| Surgical/Hospitalization History |
|   |
|  |

 ­­­­­­­­­­­­­­­­­­­­­­­­­

|  |  |  |  |
| --- | --- | --- | --- |
| Social History  | Yes  | How many  | No  |
| Smoke- Cigarettes/Tobacco products |   |   |   |
| Alcohol |   |   |   |
| Coffee  |   |   |   |

Other Doctors (includes Cardiologist/Urologist/Endocrinologist) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females only:** Are you pregnant, planning pregnancy or nursing a child: Yes / No

**PERSONAL MEDICAL HISTORY**

**Have you ever had any of the following (check all that apply):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Chest pain |   | Arthritis |   | Depression |   | Ulcers |   | TB/lung disorders |   |
| Hypertension |   | Difficulty hearing |   | Blood in Stool |   | Skin disorder |   | Shortness of Breath |   |
| Heart Attack |   | Anemia |   | Asthma |   | Hepatitis |   | Allergies |   |
| Stroke |   | Memory loss |   | Dizzy spells |   | Cataracts |   | Eczema |   |
| Headaches |   | Hemorrhoids |   | Cancer |   | Digestive Problems |   | urinary infections |   |

**Hepatitis C risk factor**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Blood transfusion prior to 1992  |   | IV drugs use (1+ times)  |   | Body Piercing |   |
| Shared razor/Toothbrush |   | Contact with blood/bodily fluid |   | Tattoos |   |

 **Immunizations---- (Year last received, if known)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Small pox |   | Tetanus |   | Typhoid |   | Hepatitis |   | Shingles |   |
| Polio |   | Influenza |   | Pneumonia |   | Rubella |   | Covid-19 |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family History** | Mother  | Father | Maternal Parents | Paternal Parents | Siblings |
| Kidney Disease |   |   |   |   |   |
| Kidney Stones/Cyst |   |   |   |   |   |
| Kidney Cancer |   |   |   |   |   |
| Dialysis |   |   |   |   |   |
| High Blood Pressure |   |   |   |   |   |
| Diabetes |   |   |   |   |   |
| Gout |   |   |   |   |   |
| Polycystic Kidney Disease  |   |   |   |   |   |
| Heart Disease |   |   |   |   |   |
| Thyroid Disease  |   |   |   |   |   |
| Cancer |   |   |   |   |   |

**Insurance Assignment and Release**

Patients Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.

I, the undersigned have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 (Name of insurance company/companies)

 And assign to **Dr. Indu Sharma and Dr. Mayur Patel** all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize **Dr. Sharma and/or Dr Mayur Patel** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I request that payment of authorized Medicare benefits be made either to me or on behalf to **Dr. Indu Sharma or DR Mayur Patel** for any services furnished me by that physician.

I authorize any holder of medical information about me release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to and authorize release of medical information necessary to pay the claim. **If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown**. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Due to the recent changes in the healthcare insurance industry, we are required to have you sign and date this form: It’s the patient’s responsibility to know their exact insurance coverage. In the event you fail to notify us about the changes in your coverage you hereby agree to have those claim become your responsibility.**

Signature of Insured/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Designation of Certain Relatives, Close Friends and Other Caregivers:** A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care. In that case, Physician Practice will disclose only information that is directly relevant to the person’s involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner **(check all that apply)**:

|  |  |  |
| --- | --- | --- |
| **Telephone, Written Communication**  | Cell Phone  | House Phone  |
| Ok to leave a message with detailed information |   |   |
| Leave message with call back number only  |   |   |

Who May we leave a message with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making limited disclosures described above. I understand that I am not required to list anyone I also understand that I may change this list at anytime in writing.

The following person(s) are authorized to receive my Patient health Information (PHI)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following person(s) **are not authorized** to received my Patient health Information (PHI)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions don’t apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep record of Patient Health Information disclosures. Information provided above will constitute an adequate record. Uses and disclosures for Treatment, payment and Health Care Operations may be permitted without prior consent.

**Payment Policy and Cancellation Fee Policy**

We have initiated a cancellation fee for missed office appointments visits to ensure that patients are seen in the office as quickly as possible. When patients miss appointments, we miss opportunities to see patients as quickly as we can.

**Office Visits**

If a patient misses an appointment and **does not give 48 hours notification, then the patient will be charged $50.00.** The patient will not be seen again in the office until this bill is paid. We do recognize that unforeseen events can occur. The Doctor on a case-by-case basis can waive the fee if there is a valid emergency. After the third missed office visit, the Doctor may ask the patient to leave the practice and seek their care elsewhere after a 30-day transition period.

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

**We accept either cash, credit, or check**

**All checks are to be made out to**:

Indu Sharma, M.D., P.A

**IF COPAYS ARE NOT RECEIVED AT THE TIME OF SERVICE THERE WILL BE AN EXTRA $15.00 FEE BILLED.**

I acknowledge that I have reviewed and read the above policy and understand my responsibilities and obligations for any missed appointments and/or copayments.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF ACCEPTANCE OF RESPONSIBILITY FOR REFERRALS AND PRIOR-AUTHORIZATIONS

I, (the patient or the responsible party on behalf of the patient) understand and agree to the following:

 My medical insurance coverage is pursuant to a contract between myself and my insurance company. I am

Responsible for understanding my rights and responsibilities under my medical insurance policy, for understanding what procedures are covered or not, and for understanding the general policies of insurance contract as they pertain to me.

Some medical procedures, tests and services may not be covered by my medical insurance policy. It is my responsibility to inquire with my insurance company to determine whether any procedure or test ordered by Indu Sharma, MD, P.A. us a covered item under my plan, and if so, to what extent. I understand that I am fully responsible for all uncovered procedures, tests and services, or any portion thereof not covered by my insurance company.

My insurance company may require that I obtain a referral from **my primary care doctor** for certain specialists’ visits, procedures, tests or services. I understand that informing the front desk and staff **and** **obtaining** such a referral **prior** to being seen is my responsibility. I further understand that the referral forms **must be obtained by me before going to any specialist, procedures, test or service**. If a prior authorization is required for any test or procedure ordered by Indu Sharma, MD, P.A., I understand it is my responsibility to inform the front desk and staff so they may obtain one.

I accept full responsibility for the consequences of not obtaining necessary referrals and/or prior authorizations at the time for my appointment. I agree to pay all charges for services rendered to me by Indu Sharma, MD, P.A., including charges for non-covered procedures by my insurance plan for my reason, including for lack of referral and/or prior-authorization.

**Patient/responsible party’s**

**Signature Date­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTICE OF HIPAA PRIVACY**

We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of any individually identifiable information that **Dr. Indu Sharma and Dr Mayur Patel** obtain from you or other that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

**Our Uses and Disclosures**

* Your protected health information will be used, as needed, by **Dr. Indu** **Sharma or Dr Mayur Patel** for purposes of treatment, payment and routine health care operations.
* We may use your Protected Health Information in a variety of other ways, although all such uses and disclosures will be subject to the restrictions of applicable law. For example:
	+ contact you to provide appointment reminders for treatment or to recommend possible treatment alternatives:
	+ disclose information to your family or friends or any other individual identified by you who is involved in your care of the payment for your care;
	+ in certain circumstances, allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies or x-rays;
	+ contact you as part of Physicians Practice’s marketing efforts;
	+ disclose your health information upon referral to a specialist or to ancillary services;
	+ disclose your health information to conduct certain research activities;
	+ Disclose your health information to comply with laws applicable to **Dr. Indu Sharma and Dr Mayur Patel.**
* Other uses and disclosures of Protected Health Information not covered by our notice or the laws that apply to **Dr. Indu Sharma and DR Mayur Patel**
* **Dr. Indu Sharma and Dr Mayur Patel** will be made only with your permission in a written authorization.
* **Your Rights**  Among other things, you have the right to:
* Request restrictions on our uses and disclosures of Protected Health Information for treatment, payment and health care operations.
* Reasonably request to receive communications by alternative means or at alternative locations.
* Inspect and copy certain Protected Health Information contained in your medical and billing records and in any other records used by **Dr. Indu** **Sharma or Dr Mayur Patel** to make decisions about you.
* Request an amendment to your Protected Health Information, but we may deny your request for amendment, in certain circumstances.

COMPLAINTS AND CONTACT PERSON

If you believe that your privacy rights have been violated, you should immediately contact the practice manager/privacy officer via telephone at 732-774-5700 or via correspondence to practice. We will not take action against you for filling a complaint.

* You also may file complaint with the Secretary of U.S. Health and Human Services. If you should have any questions or would like further information about our notice, please contact the practice manager/privacy manager or the physician practice.

**ACKNOWLEDGE OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE**

I acknowledge that I, the patient, have received a copy of the Notice of HIPPA Privacy of the

Physician Practice.

 Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECORDS RELEASE AUTHORIZATION**

**Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize and request you to release to:

Dr. Indu Sharma, M.D., P.A.

Dr. Indu Sharma M.D. and Dr. Mayur Patel M.D.

1915 6th Avenue

Neptune, NJ 07753

Phone 732-774-5700, Fax 732-774-7929

Any lab work, radiology (including x-rays, ultrasounds and CAT scans) and progress notes concerning my illness and/or treatment under your care.

Patients Name ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_

**Consent to Obtain Prescription History & E-Prescribing**

This consent form authorizes INDU SHARMA MD PA to obtain and review your prescription history, as well as electronically transmit your prescriptions directly to your pharmacy. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that INDU SHARMA MD PA can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers, pharmacies and benefit payors.

Understanding all of the above, I hereby provide informed consent to INDU SHARMA MD PA to request, view, and use my external prescription history for treatment purposes, as well as to enroll me in E-Prescribing. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signing Consent Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telehealth Consent due to COVID-19**

 “I agree to Terms of Use” on Doxy.me telehealth portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telehealth services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent, including the terms of Indu Sharma MD PA Privacy Notice described below.

If I am signing on behalf of incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

1. By using Doxy.me telehealth portal, I agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my provider and I will be able to see and speak with each other from remote locations.
2. I understand and agree that:
	* I will not be in the same location or room as my medical provider.
	* My provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
	* Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my provider’s office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
	* Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider’s inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Indu Sharma MD PA responsible for lost information due to technological failures.
	* I further understand that my Provider’s advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my provider relies on information provided by me before and during our telehealth encounter and that I must provide
	* Information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
	* I may discuss these risks and benefits with my provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to present or future treatment by my provider.
	* I understand that the level of care provided by my provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will schedule an in-office visit or go to the nearest hospital emergency department or medical doctor.
	* In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.
3. I consent to, understand and agree that:
	* I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives.
	* Indu Sharma MD PA will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
	* Indu Sharma MD PA providers will not prescribe opioids to me during a telehealth visit.
	* I have the right to review and receive copies of my medical records, including all information obtained during a telehealth interaction, subject to Indu Sharma MD PA standard policies regarding request and receipt of medical records and applicable law.
	* The laws of the state in which I am located will apply to my receipt of telehealth services.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS**

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

**Decision to Meet Face-to-Face**

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone’s well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

**Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

**Your Responsibility to Minimize Your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions\_\_\_\_

* You will only keep your in-person appointment if you are symptom free. **\_\_\_\_\_**
* You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won’t charge you our normal cancellation fee. \_\_\_\_
* You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. \_\_\_­\_
* You will wash your hands or use alcohol-based hand sanitizer when you enter the building. \_\_\_
* You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won’t move chairs or sit where we have signs asking you not to sit. \_\_\_\_­
* You will wear a mask in all areas of the office (I [and my staff] will too). \_\_\_\_
* You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. \_\_\_\_
* You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. \_\_\_\_
* No one under the age of 18 is allowed in the office. \_\_\_\_
* You will take steps between appointments to minimize your exposure to COVID. \_\_\_\_
* If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. \_\_\_\_
* If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. \_\_\_\_
* If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth. \_\_\_­­\_
* Only one person is allowed in the office if assistance is need. \_\_\_\_

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

**My Commitment to Minimize Exposure**

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

**If You or I Are Sick**

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the corona virus, I will notify you so that you can take appropriate precautions.

**Your Confidentiality in the Case of Infection**

If you have tested positive for the corona virus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Client Date