PATIENT INFORMATION SHEET

(PLEASE PRINT ANDCOMPLETEALLSECTIONSFRONTAND BACK)

EMERGENCY CONTACT PERSON:

EMERGENCY PHONE NUMBER:

IF PATIENT IS A MINOR PLEASE CHECK THIS BOX ☐

SECTION A — PATIENT INFORMATION

PATIENT ACCOUNT #

SOCIAL SECURITY #

PATIENT'S LAST NAME:

PATIENT'S FIRST NAME:

PATIENT'S MIDDLE INITIAL:

GENDER (please check one box): ☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YY):

AGE:

ADDRESS:

CITY:

STATE:

ZIP CODE:

HOME PHONE:

WORK PHONE:

CELL PHONE:

MARITAL STATUS (please check one box): ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER:

EMPLOYER ADDRESS:

PRIMARY CARE PHYSICIAN (P.C.P.):

REFERREDTO OUROFFICE BY:

SECTION B — ADDITIONAL INFORMATION

(PLEASE COMPLETE IF PATIENT IS A MINOR)

FATHER'S NAME:

MOTHER'SNAME:

PARENTS ARE (please check one box): ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED

IF PARENTS ARE DIVORCEDOR SEPARATED; ABSENT PARENT(S) ADDRESS&PHONENUMBER:

SECTION C — BILLINGINFORMATION

(PERSON RESPONSIBLE FOR BILL, IF DIFFERENT THAN ABOVE)

NAME:

ADDRESS:

CITY:

STATE:

ZIPCODE:

HOME PHONE:

WORK PHONE:

CELL PHONE:

RELATIONSHIP TO PATIENT (please check one box): ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ SELF ☐ OTHER:

SOCIAL SECURITY #

EMPLOYER:

SECTION D — INSURANCE INFORMATION

PRIMARY INSURANCE INFO	SECONDARY INSURANCE INFO
COMPANY:	COMPANY:
ADDRESS:	ADDRESS:
INSURED (NAME ON CARD):	INSURED (NAME ON CARD):
I.D. # / DATE OF BIRTH (MM/DD/YY):	I.D. # / DATE OF BIRTH (MM/DD/YY):
GROUP #	GROUP #
GROUP NAME:	GROUP NAME:

SECTION E AUTHORIZATIONS

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Ralph Bharati M.D., P.A. for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financial Administrations and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date Signed: _____

Please INITIAL all sections: _____ CONSENT TO TREAT: I hereby grant consent for treatment or services to be provided by Ralph Bharati M.D., P.A. I also certify that no guarantee or assurance has been made as to the results which may be obtained.

_____ RELEASE OF MEDICAL INFORMATION: I consent to the release of my medical records by Ralph Bharati M.D., P.A. for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance company or managed care organization.

_____ PATIENT RIGHTS: I acknowledge that I have received, read & understood Ralph Bharati M.D., P.A. Client Rights & Responsibilities.

_____ NOTICE OF INFORMATION POLICY: I acknowledge that I have reviewed the Ralph Bharati M.D., P.A. Notice of Information Policy posted in the reception room. I understand this notice explains how my medical information may be used and shared under HIPAA. By receiving care, I consent to be contacted by PsychCareKS via phone, voicemail, text message (SMS), email, or other secure systems for appointment reminders, scheduling updates, and care coordination. Message frequency may vary; standard message and data rates may apply. I may opt out at any time by notifying the clinic or replying STOP to any text.

☐ By checking this box, you agree to receive text messages from PsychCareKS. Consent is not a condition of purchase. Message frequency varies. Message and data rates may apply. You can unsubscribe at any time by replying STOP. Text HELP to get help. Policy: www.psychcareks.com/privacy

_____ *PAYMENT / INSURANCE PAYMENTS OF BENEFITS: I understand I am responsible for all charges for services and treatments rendered. However, as a courtesy and on my behalf, Ralph Bharati M.D., P.A. will bill my insurance company; I understand that I am responsible for deductibles, co-pays, or any amount not covered by my insurance. I authorize payment of benefits to be made on to Ralph Bharati M.D., P.A. for medical services provided.*

_____ CANCELLATION/NOSHOW POLICY: You must provide a minimum of 24-hour notice to cancel or reschedule your appointment. Any appointment that is cancelled/rescheduled with less than 24-hour notice or missed without notification (NO SHOW), will be charged a $60.00 LATE CANCELLATION/NO SHOW fee. The LATE CANCELLATION/NO SHOW fee is the sole responsibility of the patient/guardian and must be paid in full before the patient's next appointment.

_____ NO SHOW DISMISSAL POLICY: If patient does not provide notification for not being able to attend his or her appointment (NO SHOW) for three (3) or more scheduled appointments, then that patient may be terminated/dismissed as a patient from Ralph Bharati M.D., P.A.

By signing below, I agree to all of the terms stated above:

Patient's Signature:_____ Date Signed:_____
Insured's Signature:_____ Date Signed:_____
(if other than the patient)

Parent or Guardian's Signature:_____ Date Signed:_____
(for patients under 18 years old)