# Mukesh Patel, MD FCCP

***Diplomate American Board of Pulmonary, Critical Care and Internal Medicine***

## PATIENT INTRODUCTION

***Please complete both sides in its entirety.***

DATE _____ PATIENT _____ AGE _____

BIRTH DATE: _____ SEX: _____ SOCIAL SECURITY # _____

PHONE # _____ CELL#_____ EMAIL:_____

MARTIAL STATUS: _____ RACE: _____ ETHNICITY [HISPANIC OR NON-HISPANIC] : _____

FLORIDA ADDRESS: _____

OUT OF STATE ADDRESS: _____

OUT OF STATE PHONE# _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE: _____ PREFERRED LANGUAGE:_____

PRIMARY PHYSICIAN: _____PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU :_____ DO YOU HAVE A LIVING WILL? _____

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**EMPLOYMENT INFORMATION**

EMPLOYMENT STATUS: _____ EMPLOYER NAME: _____

WORK# _____ EXT _____ OCCUPATION: _____

ADDRESS _____

MAY WE CONTACT YOU AT YOUR WORK NUMBER LISTED ABOVE: _____

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**INSURED INFORMATION [IF OTHER THAN PATIENT]**

INSURED:_____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH_____ SOCIAL SECURITY# _____ HOME PHONE _____

HOME ADDRESS _____

EMPLOYER NAME: _____ WORK#_____

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**DESIGNATED EMERGENCY CONTACTS**

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency: I authorize discussion of my General Medical Condition and Diagnosis (including treatment, payment and healthcare operations) with:

NAME _____ RELATIONSHIP_____ PHONE _____

NAME _____ RELATIONSHIP_____ PHONE _____

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**OVER ➔**

# Mukesh Patel, MD FCCP

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**PERMISSION FOR TREATMENT**

I hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Mukesh Patel, MD deemed advisable and necessary in the diagnosis and treatment of my condition.

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**AUTHORIZATION AND ASSIGNMENT**

I hereby authorize payment to be made to Mukesh Patel, MD, PA and benefits otherwise payable to me. As a courtesy to our patients, our office will file all insurances to the best of our efforts. In order for us to continue this courtesy, we must receive payment in full within 60 days from the service date or when the balance becomes patient responsibility. We require payment at time of service when the insurance assigns copays, coinsurances, deductibles or pays the patient directly.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance due on my account. Furthermore, it is my understanding that if any portion of my balance remains unpaid over 30 days from the date of service, without an arrangement, my account may be sent to collections.

I am being informed that canceling and rescheduling appointments are not allowed besides for unforeseen emergencies. Our office policy is to release a patient from our practice for two consecutive canceled, rescheduled, or no show appointments.

I agree to pay a fee of $25.00 for any appointments that are not kept. I understand that these fees will not be covered by my insurance and I will be responsible to pay them in full before scheduling my next follow up appointment. I also agree to pay a fee of $30.00 per check for each returned check.

***Please be advised that you will receive a separate bill for any outside diagnostic and/or laboratory tests.***

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**RELEASE OF INFORMATION**

I hereby authorize any information about me to be released to determine the benefits for services provided and to process any medical claims.

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**PRIVACY NOTICE**

Signature below is an acknowledgment that I have received the Notice of our privacy practices as required by HIPPA.

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**I have read and completed each of the above sections. I have presented my current insurance card(s) to be scanned and attached to my file. I certify that all information is true and correct to the best of my knowledge. It is my responsibility to notify this office of any and all changes in my health status, insurance or any of the information given above.**

**Signature: _____ Date: _____**