BHAWNA BAHETHI, M.D. LLC

Bhawna Bahethi, M.D.

1600 Crain Hwy South, Ste 501
Glen Burnie, Maryland 21061
Telephone 410.766.8911
Facsimile 410.766.8977

PATIENT REGISTRATION

TODAY'S DATE

Welcome to our office. We are committed to providing you the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PATIENT INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME | AGE | DATE OF BIRTH

PARENT'S NAME *IF A MINOR* | SOCIAL SECURITY # | SEX | MARITIAL STATUS

CELLPHONE | HOME TELEPHONE | WORK TELEPHONE | DRIVER'S LICENSE #

E-MAIL ADDRESS

HOME ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS *IF DIFFERENT* | CITY | STATE | ZIP CODE

OCCUPATION | PATIENT'S EMPLOYER

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

SPOUSE'S NAME | SPOUSE'S EMPLOYER | EMPLOYER'S TELEPHONE

NOTIFY IN CASE OF EMERGENCY

NAME OF CONTACT PERSON | RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE

ADDRESS | CITY | STATE | ZIP CODE

NEAREST RELATIVE *NOT LIVING WITH YOU* | RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

NAME | RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE

ADDRESS | CITY | STATE | ZIP CODE

PRIMARY INSURANCE COMPANY | CLAIM ADDRESS | TELEPHONE

SUBSCRIBER'S NAME | INSURANCE ID # | SOCIAL SECURITY # | DATE OF BIRTH

SECONDARY INSURANCE COMPANY | CLAIM ADDRESS | TELEPHONE

SUBSCRIBER'S NAME | INSURANCE ID # | SOCIAL SECURITY # | DATE OF BIRTH

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INSURANCE AUTHORIZATION

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ DATE OF BIRTH _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have Insurance coverage and assign directly to BHAWNA BAHETHI, M.D. LLC all insurance 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 my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

SIGNATURE OF PATIENT / PARENT / AUTHORIZED REPRESENTATIVE _____ DATE _____

FINANCIAL AGREEMENT

Please read the following statements carefully. Ask for clarification if you have questions.

* I hereby authorize my health plan or insurance company to pay BHAWNA BAHETHI, M.D., LLC directly all insurance benefits for professional services rendered.

* I understand that I am financially responsible for charges not covered by my health insurance.

* I understand that all deductibles and co-pays are due and payable at the time of the office visit.

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ RELATIONSHIP TO PATIENT _____

PATIENT'S SIGNATURE _____ DATE _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices* .

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ RELATIONSHIP TO PATIENT _____

PATIENT'S SIGNATURE _____ DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: