**Aditi Swami, M.D.**
**2600 N. US Hwy 75, Ste. 120**
**Sherman, TX 75090**
**Phone: 903-416-6385 Fax: 903-416-1737**

Patient Name: Last _____ First _____ Middle _____

DOB: _____ M: ___ F: ___ Patient's Social Security #: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Emergency Contact: _____ EC Phone: _____ Relationship: _____

Guarantor if different than patient: _____

DOB: _____ Social Security #: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip _____

Primary Insurance: _____ ID# _____ Ins. Phone: _____

Subscribers Name: _____ Subscribers DOB: _____

Secondary Insurance: _____ ID# _____ Ins. Phone: _____

Subscribers Name: _____ Subscribers DOB: _____

X ____ (Initial) Consent for treatment: The patient agrees to general medical treatment by Aditi Swami M.D. and understands and consents to the review and use of his/her medical records. All professional services rendered are charged to the patient.

X ____ (Initial) Responsibility for payment: I understand that Aditi Swami M.D. bills my insurance company as a courtesy but I am responsible for payment to Aditi Swami M.D. regardless of my insurance company. I also understand that the billing department is not ultimately responsible for collection from my insurance company.

X ____ (Initial) Assignment of Benefits: I authorize my insurance carriers to pay benefits directly to Aditi Swami M.D. on any unpaid services filed on my behalf.

X ____ (Initial) Authorization to Release Information: I hereby authorized Aditi Swami M.D. to release any medical information and any necessary data pertinent to the filing of insurance claims in the interest of the patient named above and the facility.

X ____ (Initial) HIPAA-Notice of Privacy Practices: This notice describes how medical information about you and/or your spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that I have been offered a copy of the "Notice of Privacy Practices."

X _____ _____

**Patient signature/Guarantor if patient is a minor** **Date**

**PATIENT HISTORY**

Patient's Name: _____ Date of Birth: _____

Other Physicians (attach separate piece of paper if necessary)

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Are you taking any prescribed medications or dietary supplements? If yes, please list.

| Medication | Strength | Frequency | Medication | Strength | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Allergies

| Name of (Medication, Food, etc) | Type of Reaction | Name of (Medication, Food, etc) | Type of Reaction |
|---|---|---|---|
| | | | |
| | | | |

Social History

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you smoke? | | Yes | | No | If yes, how much? | |
| Do you have a history of smoking? | | Yes | | No | Date quit smoking: | |
| Do you drink alcohol? | | Yes | | No | If yes, how often? | |
| Do you use any street drugs? | | Yes | | No | If yes, what kind and how often? | |

Have you ever been told you had one of the following? If yes, please describe:

| | | | | | |
|---|---|---|---|---|---|
| Lung disease | | yes | | no | |
| High blood pressure | | yes | | no | |
| Heart trouble | | yes | | no | |
| Disease or disorder of the digestive tract | | yes | | no | |
| Any form of cancer | | yes | | no | |
| Disease of the kidney | | yes | | no | |
| Diabetes | | yes | | no | |
| Arthritis | | yes | | no | |
| Hepatitis | | yes | | no | |
| Malaria | | yes | | no | |
| Stroke | | yes | | no | |
| Tuberculosis | | yes | | no | |
| Disease or disorder of the blood | | yes | | no | |

| **Previous Surgeries** | **Date** | **Have you been hospitalized in the past year? Describe.** | **Date** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PATIENT HISTORY**

**PATIENT PRIVACY DIRECTIVE**

***In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.***

Please provide us with the name and phone number(s) of anyone we may talk to regarding your appointments, treatments, test results, and billing:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

You must inform us in writing of any changes in your directives.

Pharmacy Name _____ City _____ Phone _____

Patient Signature X _____ Date _____

# RELEASE OF INFORMATION FOR MEDICAL RECORDS OF:

PATIENT NAME _____

PATIENT ADDRESS _____

PATIENT DATE OF BIRTH _____

PATIENT DATE OF SERVICE _____

PATIENT TELEPHONE # _____

PATIENT SS# _____

I hereby authorize _____ to release information and forward to:

Provider

Aditi Swami, M.D.
2600 N. US Hwy 75, Ste. 120
Sherman, TX 75090
Phone: 903-416-6385 Fax: 903-416-1737

Please check type of information to be released

| | | | | | |
|---|---|---|---|---|---|
| | Complete Medical Record | | Lab Results | | X-Ray Results/Film |
| | Notes/Results for Date of Service: | | Consultation Reports | | Billing Record |
| | Immunizations | | Other, specify | | |

Please check the reason the above information is released

| | | | | | |
|---|---|---|---|---|---|
| | Transfer to another Physician | | Legality Purposes | | Specialist/2nd Opinion |
| | Personal File | | Disability Benefits | | Other, specify |

I understand that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.
I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
However, no protected information will be released without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy of Individually Identifiable Health Information (45 CFR parts 160 & 164).
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire in 180 days from the date of my signature on or otherwise specified by date, event or condition as follows: _____
I further authorize that a photocopy of this authorization is acceptable as an original.
I understand that I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing law.

Divorced Parents: This is to certify that I, _____, have full access to my child's medical record according to the divorce decree granted by the court.
*Patient/Parent/Guardian Name: _____
*Patient/Parent/Guardian Signature: _____

**X** _____ _____

Signature of Patient or Legal Representative — Date

_____

Relationship to Patient

Identity of Requestor Verified via: __Photo ID ___Matching Signature ___Other, specify _____
PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal & State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Date of Request _____ Record copying cost: $_____.00 _____ Cash _____ Check# _____ _____C.C.

We would like to thank you for choosing Aditi Swami, PA. for your health care needs. Whether you came to us by referral of another Physician, by direction of your insurance company, or like many others, by the referral of a friend or relative, we will strive to provide to you the most complete and up-to-date care possible. Below, you will find our office policy regarding payment contracts, insurance filing, co-pays and collections. We hope this information will be helpful and will prevent any misunderstanding in the future. Please don't hesitate to ask any questions which may arise regarding our practice.

*All patients complete a "Patient Information/History Form" before being seen the first time. A current and valid insurance card should be presented at the time of your first appointment.*

*All fees are due at the time of service unless prior arrangements have been made with the Business Office. Payment arrangements are to be made prior to your appointment time. We will be happy to file your insurance for you, if you will provide us with a valid ID card.*

*We accept three methods of payment: Credit card, Cash or Check. Should your check be returned to us unpaid, there will be a $25.00 service fee charged to your account.*

*At any time during your care with us, we ask that you please notify the "check-in" personnel of any changes in your personal information: Insurance, Address, Telephone numbers, Employment, etc. Periodically, you will be asked to complete an updated information form for your file.*

**Managed Care Insurance:**

If we are participants of your plan, we will be happy to file your charges for you. Your co-payment, however is due at the time of your appointment.

A current active insurance ID card is required for each visit in which you wish to have us bill your insurance.

**Medicare Recipients:**

Aditi Swami, M.D. is a participating provider. We will file all charges for you, as well as any supplemental policies you have. Please bring your ID cards with you.

**Account Delinquency:**

All balances are the responsibility of the patient. If your insurance has not paid, this becomes your responsibility. Accounts become delinquent after 60 days. Our financial counselors can set up a budget plan for payment of larger balances. We ask that if you are not able to pay your balance in full within the 60 day period, to contact the Business Office. If we do not have a budget plan established for your account, collection proceedings will be initiated. Failure to take care of your financial responsibilities could jeopardize your relationship with this clinic. All collection accounts must be paid in full before future care in this office will be permitted.

We are pleased to have the opportunity to serve you, and will do our best to file your claim in a timely and professional manner. If you have any questions regarding our billing and collection practices, please ask. Again, thank you for allowing us to serve you.

X _____ _____

Patient Signature Date

# PATIENT RIGHTS AND RESPONSIBILITIES

ACCESS OF CARE

Aditi Swami, PA. does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment or participation in its programs, services and activities, or in employment.

NOTICE OF RIGHTS

- You or your representatives have a right to be informed of your rights before care is started or discontinued whenever possible.
- You have a right to prompt resolution of grievances.
- Patients and family members have the opportunity to inform the hospital of complaints concerning quality of care. While in the hospital the complaint can be made to the hospital Patient Representative, Nurse Manager, or Administrative supervisor on duty by dialing "0". After discharge, the complaint may be communicated in a letter to the President or directed to the Quality Management Department, by calling 903-416-4130.
- Complaints about Physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including Physician Assistants and Acupuncturists, may be reported for investigation at the following address:
    - Texas State Board of Medical Examiners
      Investigation Department
      PO Box 2018
      Austin, TX 78768-2018
- Assistance in filing a physician complaint with this authority is available by calling the following phone number:
    - 1-800-201-9353

EXERCISE OF RIGHTS

- You have the right to participate in the development and implementation of your plan of care.
- You or your representative (as allowed under State Law) has the right to make informed decisions regarding your care. Your rights include being informed of your health status and prognosis, being invoked in care planning and treatment, including pain management, and being involved in care planning and treatment, including pain management, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
- You have the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.
- You have the right to have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital.
- You, and when appropriate, your family, have the right to be informed about outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

PRIVACY AND SAFETY

- You have the right to personal privacy.
- You have the right to receive care in a safe setting.
- You have the right to be free from all forms of abuse or harassment.
- You have a right to an environment that preserves dignity and contributes to a positive self-image, which includes storage space to meet the patient's personal needs.
- You a right to access protective and advocacy services.

CONFIDENTIALITY OF PATIENT RECORDS

- You have the right to the confidentiality of your medical records.
- You have the right to access information contained in your records within a reasonable time frame.

COMMUNICATIONS

- You have the right of access to people outside the hospital by means of visitors and by written communication appropriate to your age, understanding, and to your language.
- When communication restrictions are medically necessary, you have the right to have these restrictions fully explained.
- You have the right to an interpreter for free, if a language barrier or sensory impairment exists.
- You have the right to communicate regardless of visual, sensory speech, hearing, language, and/or cognitive impairments at no cost to you (FREE).

SPIRITUAL CARE

- You have the right to spiritual care through access to pastoral care including the hospital chaplain and other spiritual services.
- A patient may contact the Patient Representative and/or the Chaplain at ext. 4130/4118, if he/she has any ethical concerns with their care.

## PATIENT RESPONSIBILITES

PROVISION OF INFORMATION

- You have a responsibility to provide accurate and complete information related to your symptoms or reason to visit, past illnesses, hospitalizations, medication, or other matters of care and to report unexpected changes in your condition.
- You are responsible to report that you understand or do not understand the treatment plan and what is expected of you.

COMPLIANCE WITH INSTRUCTION

- You are responsible for following the treatment plan and instructions of health care providers.
- You are responsible for keeping appointments or for notifying the appropriate person if you are unable to keep the appointment.

REFUSAL OF TREATMENT

- You are responsible for your actions if you refuse treatment or do not follow instructions.

RESPECT AND CONSIDERATION

- You are responsible for being considerate of the rights of others, for assisting in the control of noise, smoking, and the number of visitors.
- You are responsible for being respectful of the property of her persons and of the Hospital.