Sunita Swamy, MD, PA
1600 W 38TH ST Ste 406
Austin, TX 78731
512.394.7377

PATIENT INFORMATION

❑ New Patient

THIS PACKET MUST BE COMPLETED AND RETURNED PRIOR TO SCHEDULING YOUR APPOINTMENT.

Patient's FIRST Name:	MIDDLE:	LAST:		Social Security #:	
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:	
Home Address:	City		State:	Zip Code:	
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other	Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_____		
Mobile#: ❑ Cell ❑ Work ❑Home ( )	Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No		
Referring Physician Name:	How did you hear about our office?				
Emergency Contact (name/phone/relationship to patient):	Pharmacy (name/address/phone):				
My office does not handle, accept, or file worker's compensation claims. _____ Initial	I have read the Notice of Privacy Practices, explaining how my medical information may be used & disclosed. If requested, I am entitled to receive a copy of the Notice of Privacy Practices. _____ Initial				

POLICY HOLDER/RESPONSIBLE PARTY: Minors under 17y/o and Dependent Patients over 18y/o

Policy Holder/Person Financially Responsible [Guarantor] ❑Self Only → Skip to insurance section ❑ Other → Complete this section	Policy Holder/Guarantor's Full Name (as it appears on insurance card):	Phone: Patient's Relationship to Policy Holder/Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:

Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑90/10 ❑ 80/20 ❑ 70/30 ❑ Other: ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (complete guarantor sect.) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

Initial: _____

SUNITA SWAMY, M.D., P.A.

Adult Patient Encounter Form - New Patient

Date: Name:

HISTORY - COMPLETED BY PATIENT

1. Reason for your visit today_____

2. Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

Physician Comments - Review of systems

- ☐ General Wellness
- ☐ Eyes
- ☐ Skin
- ☐ Ears, Nose, Throat
- ☐ Stomach/Digestion
- ☐ Lungs/Breathing
- ☐ Heart/Circulation
- ☐ Muscles/Joints/Bones
- ☐ Neurological
- ☐ Allergies
- ☐ Reproductive/Urinary
- ☐ Thyroid/Endocrine
- ☐ Psychiatric
- ☐ Blood/Lymph
- ☐ Other

☐All other systems negative ROS: 1 prob pertinent, 2-9 extended, 10+ complete

3. Past Medical History:

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Diabetes	yes	no	Heartburn/GERD	yes	no	Migraine Headaches	yes	no
High Blood Pressure	yes	no	Thyroid disease	yes	no	Osteoporosis	yes	no
Heart Disease	yes	no	Mental illness	yes	no	Pneumonia	yes	no
Stroke/CVA	yes	no	Anemia	yes	no	Seizures	yes	no
High Cholesterol	yes	no	Arthritis	yes	no	Tuberculosis	yes	no
Cancer	yes	no	Bladder Infections	yes	no	Other: _____		
If yes, what type: _____			Glaucoma	yes	no	_____		
Asthma	yes	no	Hemorrhoids	yes	no	_____		
Allergies	yes	no	Hernia	yes	no	_____		

4. How many times have you been pregnant? _____ Number of completed: pregnancies _____ abortions _____ miscarriages _____

5. Previous Surgeries/Dates:

6. Have you had any blood transfusions? yes no

7. Childhood Diseases

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Chickenpox	yes	no	Polio	yes	no	Diphtheria	yes	no
Measles	yes	no	Rheumatic Fever	yes	no	Whooping Cough	yes	no
Mumps	yes	no	Scarlet Fever	yes	no	Rubella	yes	no

8. Have you ever had any sexually transmitted diseases (STDs) or venereal diseases? yes no

If yes, what type(s):_____

9. Last menstrual period: _____ (month/day/year)

SUNITA SWAMY, M.D., P.A.

Name:

10. Allergies to medications: Allergies to foods:

11. Medication(s) (Names and Dosages) Please include all over the counter medications, supplements, and aspirin

12. When was your last:

Pap smear	_____	normal abnormal	Chest X-ray	_____	normal	abnormal	Pneumovax	yes	no
Breast Exam	_____	normal abnormal	Cholesterol level	_____	normal	abnormal	Tetanus shot	_____	
Mammogram	_____	normal abnormal	Colonoscopy/Flex Sig	_____	normal	abnormal			
Bone Density	_____	normal abnormal	Blood sugar level	_____	normal	abnormal			
PSA	_____	normal abnormal	EKG	_____	normal	abnormal			
Rectal Exam	_____	normal abnormal	Echocardiogram	_____	normal	abnormal			
Eye Exam	_____	normal abnormal	Stool test	_____	yes	no			
Dental Exam	_____	normal abnormal							

13. Family History

	Diabetes	High Blood Pressure	Heart Disease	Stroke/CVA	High Cholesterol	Cancer (Type)	Osteoporosis	Mental Illness	Other
Father									
Mother									
Siblings									
Children									
Other									

14. What is your Social History?

Current Occupation/Employer_____ What kind of work?_____

Marital Status: Single Divorced Married Widow/Widower Who lives with you?_____

Do you smoke?_____ How many packs a day?_____ For how many years?_____

Do you drink alcohol?_____ How many drinks? _____ per day _____ per week _____per month

Do you use illicit drugs?_____ If yes, what kind?_____

Do you drink caffeine? _____ How much per day? _____

Do you consider your diet: Healthy Unhealthy

Do you exercise? _____ How many times per week?_____ For how long? _____ What type? _____

15. If this is your annual physical:

Are you sexually active? yes no

If yes, number of current partners: _____ number of lifetime partners: _____

Method of Contraception: _____

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge.

I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I authorize my insurance benefits be paid directly to Sunita Swamy MD PA, as indicated on the claim, and I affirm that the insurance information provided above is up-to-date & valid.

_____
Initial

I understand that I am financially responsible for all fees and balances, including but not limited to those listed below, regardless of insurance coverage:

- Medical Records Fee:
  Per the Texas Medical Board rules including Section 165.2, the fee for Medical Records starts at $25 and increases depending on the total number of pages.

- Paperwork Processing Fees:
  There may be a fee for paperwork not exceeding $50, depending on the forms, information needed, and the time required to fill them out.

_____
Initial

Guarantor/Guardian signature: _____ Date _____

Initial: _____

Sunita Swamy MD PA

Financial Policy

Effective November 1, 2017 **Patient Name:_____**

Thank you for choosing Sunita Swamy MD PA as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due to us are recovered which will then allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible.

1. _____ I understand that my appointment may be rescheduled if I do not have proof of valid and current insurance, have not properly listed Dr. Swamy as my PCP if required, and / or I do not have the ability to pay my financial responsibility (co-payments, deductible or coinsurance rates) at the time of service.

2. _____ I understand that Sunita Swamy MD PA will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Sunita Swamy MD PA. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Sunita Swamy MD PA at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ Should my insurance company request, it is my responsibility to provide my insurance company with the information needed to process a claim for services. It is also my responsibility to notify Sunita Swamy MD PA if there is any change in my insurance coverage, residence, or phone number. Ultimately, it is up to me to know my insurance benefits.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ Date:_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Sunita Swamy MD PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ Date:_____

Sunita Swamy MD PA
PH: 512.394.7377

1600 W 38TH Ste 406
Austin, TX 78731

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Dr. Sunita Swamy to verbally release my confidential health information to the person(s) or entity(ies) listed below.

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Do Not Include the following:
(*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

_____ X-Ray Results

_____ Lab Results

_____ Referral Information

_____ Medications

Other:_____

I Do Not Want my confidential health information to be disclosed.	**Signature:** _____

Initial_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider as addressed below and I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Privacy Officer
1600 W 38TH ST Ste 406
Austin, TX 78731

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** unless I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I have not initialed the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws

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SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

Initial_____