WELCOME

JRP MEDICAL GROUP, INC
Jyothi Reddy, M.D., FACG, FASGE, FACP
Board Certified In Gastroenterology & Internal Medicine
9670 Magnolia Ave., Ste. 203 Riverside, CA, 92503
Phone: (951) 354-3976 Fax: (951) 354-2024

A PATIENT INFORMATION

Date ______________________

Patient Name ______________________

Address ______________________

____

City State Zip

Sex: ☐M ☐F Age ________ Birthdate ____________

☐Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Reason For Your Visit ______________________

Primary Language ____________ SS# ____________

Occupation ______________________

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Spouse's Name ______________________

Birthdate ____________ SS# ____________

Occupation ______________________

Spouse's Employer ______________________

C PHONE NUMBERS

Home ____________ Cell ____________

Work ____________ Best Time/Place To Reach You ________

IN CASE OF EMERGENCY CONTACT

Name ____________ Relationship ____________

Home Phone ____________ Work Phone ____________

B INSURANCE

Who Is Responsible For This Account? ______________________

Subscriber Name (If NOT Patient) ______________________

Relationship to Patient ______________________

Birthdate ____________ SSN# ____________

Primary Insurance Name ______________________

ID # ____________ Group # ____________

Secondary Insurance Name ______________________

ID # ____________ Group # ____________

ASSIGNEMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named company(s) and assign directly to **JRP MEDICAL GROUP, INC** all insurance benefits, if any, otherwise payable to me by services rendered. I understand that I am financially responsible for all charges whether or not paid by 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 insurance submissions.

______________________ ____________
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of Medicare Benefits be made either to me or on my behalf to **JRP MEDICAL GROUP, INC** for any services furnished me by that physician group. I authorize any holder of medical information about me to release Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________ ____________
Beneficiary Signature Date

JRP MEDICAL GROUP, INC

JYOTHI A. REDDY, M.D., FACG, FASGE

GASTROENTEROLOGY

9670 MAGNOLIA AVE., STE. 203

RIVERSIDE, CA, 92503

PHONE: (951) 354-3976 FAX: (951) 354-2024

NAME: ______________________ DATE: ______________________

REASON FOR VISIT: ______________________________________

PATIENT Illness/Surgery   Year

______________ ____

______________ ____

______________ ____

______________ ____

______________ ____

______________ ____

Do you smoke? Yes No

Packs per day: ________
Years smoked: ________

Do you use alcohol? Yes No
drinks per week: __________

MEDICINES: (List all prescriptions over-the-counter drugs, vitamins, herbal, etc.):

____

____

____

____

____

____

____

____

____

____

____

FAMILY History

Disease	Relationship
Cancer	________
Colon Polyps	________
Ulcer	________
Liver Disease	________
Pancreatitis	________
Other	________

ALLERGIES:

Drug: ______________________

____

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REVIEW OF SYSTEMS

CONSTITUTIONAL
- Recent Weight Loss ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No

EYES
- Blurred Vision ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No

EARS/NOSE/MOUTH/THROAT
- Recent hearing loss ☐ Yes ☐ No
- Mouth sores ☐ Yes ☐ No

CARDIOVASCULAR
- Chest pain ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Swelling of ankles ☐ Yes ☐ No

RESPIRATORY
- Chronic cough ☐ Yes ☐ No
- Coughing up blood ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No

GENITOURINARY
- Burning with urination ☐ Yes ☐ No
- Blood in urine ☐ Yes ☐ No

MUSCULOSKELETAL
- Joint pain or ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Muscle pain ☐ Yes ☐ No

SKIN
- Rash ☐ Yes ☐ No
- Itching ☐ Yes ☐ No

Have you seen/heard our TV/radio ads? ☐ Yes ☐ No

GASTROINTESTINAL
- Poor appetite ☐ Yes ☐ No
- Difficulty in swallowing ☐ Yes ☐ No
- Heartburn ☐ Yes ☐ No
- Nausea or vomiting ☐ Yes ☐ No
- Bloating ☐ Yes ☐ No
- Belching ☐ Yes ☐ No
- Regurgitation ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Abdominal pain ☐ Yes ☐ No
- Recent change in bowel habits ☐ Yes ☐ No
- Rectal bleeding ☐ Yes ☐ No
- Black, tarry stools ☐ Yes ☐ No

NEUROLOGICAL
- Headaches ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Strokes ☐ Yes ☐ No
- Numbness ☐ Yes ☐ No

PSYCHIATRIC
- Memory loss or confusion ☐ Yes ☐ No
- Depression ☐ Yes ☐ No

ENDOCRINE
- Heat or cold intolerance ☐ Yes ☐ No
- Excessive thirst or urination ☐ Yes ☐ No

HEMATOLOGICAL
- Bleeding or bruising tendency ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Past transfusion ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

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DATE: ____________________

NAME: ____ REFERRED BY: ____________________

DATE OF BIRTH: ____________________

S.S#: ____

STREET ADRESS ____ PHONE NUMBER ____________________

CITY, STATE, ZIP ____

INSURANCE ____________________ ID #: ____________________ POLICY/GROUP #: __________

OCCUPATION/EMPLOYER ________________________________ PHONE NUMBER ____________________

SPOUSE'S NAME ________________________________

SPOUSE'S OCUPATION/EMPLOYER ____________________________ PHONE NUMBER ____________________

EMERGENCY CONTACT
(OTHER THAN SPOUSE)
NAME: ____________________ PHONE NUMBER____________________ RELATION __________

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Jyothi Reddy for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Jyothi Reddy to release any medical or incidental information that may be necessary for either medical care in processing applications for financial benefit.

MEDICARE/MEDICAID

I certify the information by me in the applying for payment is correct. I authorize release of all records on request. I request payment of authorized benefits to be made on my behalf.
A photocopy of these assignments shall be valid as the original.

Patient Name ________________________________ Date ____________________

Parent/Guardian ________________________ Signature ____________________________

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ADVANCE HEALTH CARE DIRECTIVE

DEAR PATEINT,

AS YOUR PHYSICIAN, WE ARE REQUIRED TO ASK ANY PATIENT OVER THE AGE OF 18, IF THEY HAVE AN EXISTING ADVANCE HEALTH CARE DIRECTIVE, SO THAT WE CAN INCORPORATE THE INFORMATION INTO YOUR MEDICAL RECORD. YOU ARE NOT REQUIRED TO GIVE US THIS INFORMATION, BUT WE ARE REQUIRED TO ASK. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST.

THANK YOU.

PATIENT NAME ______________________________ SS# ______________________________

PATIENT SUGNATURE ______________________________ DATE ______________________________

- I DECLINE TO ANSWER THESE QUESTIONS. ☐YES ☐NO
- DO YOU HAVE AN ADVANCE HEALTH CARE DIRECTIVE? ☐YES ☐NO
- IF YES, PLEASE INDICATE THE TYPE OF DIRECTIVE.
  - DURABLE POWER OF ATTORNEY FOR HEALTH CARE ☐
  - CALIFORNIA NATURAL DEATH ACT ☐
  - LIVING HEALTH CARE WILL ☐
  - OTHER______________________________
- WILL YOU BRING US A COPY OF YOUR DIRECIVE?
  ☐YES ☐NO

INTERNAL OFFICE USE:

TYPE OF HEALTH CARE DIRECTIVE RECEIVED: DATE RECEIVED

- DURABLE POWER OF ATTORNEY FOR HEALTH CARE ☐ ____________
- CALIFORNIA NANTURAL DEATH ACT ☐ ____________
- LIVING HEALTH CARE WILL ☐ ____________
- OTHER ______________________________ ☐ ____________

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Practice Guidelines and Patient Financial Policies

1) **EMERGENCIES:** Our providers will make an effort to receive your calls and respond promptly in an emergency. If you do not receive and immediate response you will call 911. receive paramedic intervention. and seek the nearest emergency room.

2) **PRESCRIPTION REFILLS:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We do not weekend. walk-in. after hours. or phone call refill request.

3) **INFORMATION:** You agree to provide me with your correct name. current and correct address. cellular or other phone number. email address. insurance information. Social Security number. driver's license. or picture identification at the time of registration or as requested by the practice at any time.

4) **FINANCIAL RESPONSIBILITIES:** By these initials and your signature below. you accept financial responsibility for all charges for services rendered to you. If a minor is under your guardianship. the parent or guardian accompanying the patient assumes this liability.

5) **PAYMENT METHODS:** We accept cash. or any insurance companies in which the practice participates.

6) **APPOINTMENTS:** Our office will schedule appointment as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours [or the Friday before a Monday appt.] notice of cancellation as a courtesy to other patient seeking services. A pattern of non-cancelled missed appointments may result in discharge from the practice.

7) **FORMS FEE:** Our practice charges additional paperwork outside completion of the medical records. The following fees apply and are subject to change without notice: (A) single page forms- $5 and (B) multi-page forms - $25. (C) FMLA. immigration. disability. and driver's license forms - $25. Additional fees may apply at the discretion of the practice and upon notification to you.

8) **MEDICAL RECORDS:** <u>THE MEDICAL CHART IS PROPERTY OF THE PRACTICE.</u> However copies pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of California.

9) **INSURANCE COPAYMENTS, DEDUCTIBLES, AND COINSURANCE:** Insurance companies do not pay all fees and exclude certain services from coverage. it is your responsibility to understand your insurance plan. All co-payments. deductibles. co-insurance. or non-covered services are to be paid in a timely fashion according to office policies. If requested. and as condition of service. you agree to and "advance beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

10) **USUAL AND CUSTOMARY:** Some insurance plans may indicate that out fees are above "usual and customary." As a result your plan reduces our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such. unless we have specifically contracted with the carrier. it is expected that you will be liable for our full fees.

11) **SLOW INSURANCE RESPONCE:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider you service your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.

12) **STATEMENT POLICY:** Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of financial responsibility and you will be liable for all service fees. A late fee may be charged for patient balances due that are more than 30 days old.

13) **COLLECTION AND BANK FEES:** Account more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense. legal fees. and court cost. In addition. banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.

14) **PATIENT DISCHARGE:** That practice reserves that right to discharge a patient for any reason. Please note that discharges may occur due to failure to meet your obligations under this document. In addition, because of care quality considerations, that practice may discharge you for failure to comply with treatment plan (s) as outlined by your practice.

15) **INSURANCE CLAIMS:** If applicable. our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from you insurance company. In the event that your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy and by my signature below, I attest that I fully understand each item and agree to the terms above.

Print Name ______________________ **Signature** ______________________ **Date:** ____________

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FINIANCIAL RESPONSIBILTY

I do hereby accept financial responsibility for all charges incurred by me, and/or my minor child. I am responsible for any charges not covered by my insurance company, any co-payments, and my annual deductible, if any.

Signature ______________________________ Date ______________________

AUTHORIZATION FOR RELEASE OF RECORDS

I do hereby authorize the release of medical records and/or insurance information to appropriate doctors and insurance companies.

Signature ______________________________ Date ______________________

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AKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVATE PRACTICES, AND I HAVE BEEN PROVIDED AN OPPORTUNUTY TO REVIEW IT.

NAME_________________________________ DOB_____________________

SIGNATURE _________________________________ DATE _____________________