ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Siddhartha Rath, M.D. Notice of Privacy Practices. I hereby authorize the following additional person or persons to receive medical information regarding my care.

Authorization List

Name	Phone Number	Relationship

_____ _____

Signature of the Patient or Legal Representative Date

Siddhartha Rath, MD
3215 Omega Dr.
Arlington, TX 76014

The information requested on this form is necessary to comply with Federal Regulations, to properly establish the medical record, and to file any insurance claims. It is important that all information is completed.

PATIENT INFORMATION

Patient's Name (First, Middle, Last) :		
Date of Birth :	□ Male □ Female	SSN:
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other		
Address:		Email :
City :	State :	Zip Code :
Home Phone #	Cell Phone #	Work #
Emergency Contact:	*Relationship:*	*Phone#*
Referring Physician:		Phone #
Primary Care Physician:		Phone #

INSURANCE INFORMATION

Primary Insurance:	Policy/ID #	Group/Acct #
Name of Policy Holder:	DOB:	SSN:
Address:		Relationship to Patient:
City:	State:	Zip Code:
Employer:		Work#
Secondary Insurance:	Policy/ID #	Group/Acct #
Name of Policy Holder:	DOB:	SSN:
Address:		Relationship to Patient:
City:	State:	Zip Code:
Employer:		Work#

OTHER PATIENT INFORMATION

To which racial category does the patient most closely identify?

□ Alaskan Native □ Asian/Pacific Islander □ Black/African American □ East Indian □ Hispanic □ Middle Eastern □ Native American Indian □ White/Caucasian □ Other

What is the patient's ethnicity? □ American □ African-American □ Chinese □ Filipino □ Hispanic □ Indian □ Latino □ Native American □ Spanish □ Vietnamese □ Other (Please Specify) _____

What is the patient's language of preference? □ English □ Spanish □ Other

AUTHORIZATION TO RELEASE INFORMATION

I authorize the offices of Rajesh S. Padmanabhan, M.D. to release all Medical Information necessary to process claims for payment of services by Rajesh S. Padmanabhan, M.D.

Patient Signature Date

ASSIGNMENT OF BENEFITS

I assign and authorize payment of all medical benefits, commercial insurance, Worker's Comp, and Government Agencies directly to Rajesh S. Padmanabhan, M.D.

Patient Signature Date

PATIENT NAME: _____ DATE of BIRTH: _____
PRIMARY CARE DOCTOR: _____ REFERRING DOCTOR: _____

Please identify your PRESENT SURGICAL ILLNESS OR ILLNESSES that the surgeon is to address today

Thyroid ____ Parathyroid ____ Breast ____ Stomach ____ Liver ____ Gallbladder ____
Spleen ____ Small Intestine ____ Colon ____ Arm/Hand ____ Leg/Foot ____ Buttocks/Anus ____ Pancreas ____
Hernia at Naval, Groin (right/left) ____ Skin Lesion or lump/mass or boil ____

Please describe briefly in your own words: 1) what symptoms you experienced on what date and/or how often they occurred 2) any tests or x-rays that you may have had done 3) medications prescribed for this illness:

1) _____
2) _____
3) _____

Please list all surgeries/operations you have had:

Date	Operation Performed	Reason	Hospital/Physician

Do you have any allergies to any medications/substance: ____ Yes ____ No
If Yes, please list medication(s) and reaction:
_____

Please list any/all medications that you are taking:

Medication	Reason	Dosage	# Per Day

Please list any/all Family Medical History that you are aware of:

Disease/Health Condition	Family Member (Maternal/Paternal, if applicable)	Age of Onset

Do you smoke? ____Yes ____No Yes (but quit in year ____)
How many packs per day do you smoke? ____ How many years? ____
Do you drink alcohol? ____Yes ____No
Beer ____# per day/week/weekend
Wine or Liquor ____# per day/week/weekend
Do you use street drugs? ____Yes ____No

If female: Please provide GYN history:
#Pregnancies ____ #Live Births ____ (#vaginal ____ and/or #C-sections ____)
Last Menstrual Period ____ Birth Control ____Yes ____No
Have you ever received a BLOOD TRANSFUSION? ____Yes ____No
If Yes, please describe: ____

Preferred Pharmacy (For Electronic Prescribing)
Name/Location/Phone #: ____

PATIENT NAME: _____ DATE of BIRTH: _____

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic:

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic:

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory:

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat:

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric:

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic:

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Al'ergy Shots			
Cortisone Use			

Gastrointestinal:

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

To the best of my knowledge, the information is accurate and complete.

Patient Signature: _____ **Date:** _____

Siddhartha Rath, M.D.
3125 Matlock Road, Suite 107
Arlington, TX 76015
Phone: (817) 466-7400

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it CAREFULLY.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with SIDDHARTHA, RATH., M.D. This information is called protected health information. Specifically, "Protected Heath Information" is information about you, including demographic information (i.e. name, address, phone, etc.) that may identify you and relates to your past, present, or future physical or mental health condition and related health care services.

SIDDHARTHA, RATH., M.D. is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose of share this information with other healthcare professionals involved in you care and treatment. This NOTICE describes your rights to access and control your protected health information. It also describes how we follow those rules and use and how we disclose your protected health information to provide your treatment, obtain payment for the services you receive, manage our heath care operations, and for other purposes that are permitted or required by law.

YOUR RIGHTS UNDER THE PRIVACY RULES

The following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- ***You have the right to receive a copy of this Notice of Privacy Practices:*** We are required to provide you with a copy of this Notice of Privacy Practices, and we are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.
- ***You have the right to authorize other use and disclosure:*** This means you have the right to authorize or deny any other use of disclosure of protected health information not specified in this notice. You may revoke an authorization at any time in writing except to the extent that your physician or our office has taken an action in reliance on the use of disclosure indicated in the authorization.
- ***You have the right to designate a personal representative:*** This means you may designate a person or any persons with the delegated authority to consent to of authorize the use or disclosure of protected health information.
- ***You have the right to inspect and copy you protected health information:*** This means you may inspect and obtain a copy of protected health information about you that contained in your patient record.
- ***You have the right to request a restriction of your protected heath information:*** This means you may ask us in writing not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.
- ***You have the right to have us amend your protected health information:*** This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases we may deny your request for an amendment.
- ***You have the right to request disclosure accountability:*** This means you may request a listing of your protected health information disclosures that we have made to entities or persons outside our office.
- ***You have the right to complain:*** This means you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint.

HOW WE MAY USE OR DISCLOSE PROTECTED HEATH INFORMATION

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made in our office.

- ***For treatment:*** We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your heath care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information as necessary to a pharmacy that would fill you prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. We may also contact you to provide information about health related benefits and services offered by our office.
- ***For payment:*** Your protected health information will be used as needed to obtain payment for our health care services. This may include certain activities that your heath insurance plan may undertake before it approves or pays for the health care services we

render for you such as determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

- *For healthcare operations:* we may use of disclose you protected health information as needed in order to support the business activities of our practices. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due to diligence in connection with the sale or transfer of assets, and creating de-identified information.

OTHER PERMITETED AND REQUIRED USES & DISCLOSURES

We may also use and disclose your protected health information in the following instance. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- *To others involved in your healthcare:* Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify your protected health information that directly relates to that person's involvement in you health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in you best interest based on our professional judgment. We may use of disclose protected heath information to notify or assist in notifying a family member, person, close friend, representative, or any other person that is responsible for your care, general condition, or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician, using professional judgment, may determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
- *As required by law:* We may use of disclose your protected health information to the extent that the use of disclosure is required by law.
- *For public health:* We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information
- *For communicable diseases:* We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or conditions.
- *For health oversight:* We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- *In case of abuse or neglect:* We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you are a victim of abuse, neglect or domestic violence to the governmental entity or agency authorize to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- *To the Food and Drug Administration:* We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects/problems, or biologic product deviations, to track products, to enable product recalls, to make repairs/replacements, or to conduct post marketing surveillance as required.
- *For legal proceedings:* We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request, or other lawful process to the extent such disclosure is expressly authorized.
- *To law enforcement:* We may disclose protected health information for law enforcement purposes so long as applicable legal requirements are met.
- *To coroners, funeral directors, and organ donation:* We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- *In cases of criminal activity:* Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- *For military activity and national security:* When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.
- *For Worker's Compensation:* Your protected health information may be disclosed by us as authorized to comply with Worker's Compensation laws and other similar legally established programs.
- *When an inmate:* We may use or disclose your protected health information if you are an inmate of a correctional facility if your physician created or received your protected health information in the course of providing care to you.
- *Other required uses and disclosures:* Under the law, we must make disclosures about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.