-	Madison Medical	Ridgeland Clinic
_	REGISTRAT	ION

PLEASE PRINT

Indira K. Veerisetty, M.D. Wesley D. Granger, M.D. Kenneth P. Kaiser, CFNP Shaquita Denise Shaw, CFNP

Email:						
Date:			Home Phone	:		
			Cell Phone:			
			Work Phone	·		
Patient:						
Street Address:						
City: S	State:	Zip Code:				
Sex: Male Female (circle one) Date of Birth: _			Single M	arried Widowed	Separated Divorced (circle one)	
Social Security #		Driver's License	e#			
Employment:						
Occupation:						
Who is responsible for this account?		Relationship to P	Patient:		Contact #	
Do you have Medical Insurance? Yes No						
Primary Insurance:		Subscriber Name:			_ DOB:	
Contract #:	Group #:			Subscriber #: _		
Secondary Insurance (If any):		Subscriber Name	e:		_ DOB:	
Contract #:	Group #:			Subscriber #: _		
Medicare Medicaid (circle appropriate)	Medicare #:					
Medicaid #:		County of:				
In case of Emergency, who should we notify:			Relationshi	p:	Telephone #:	
How did you learn of our practice?		Primary	y Care Physic	tian		

CONSENT/AUTHORIZATION FOR MADISON RIDGELAND MEDICAL CLINIC

INSURANCE AUTHORIZATION- I request that payment of authorized benefits be made to the above-named doctor(s) on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in the place of the original.

I authorized the release of any medical or other information necessary to process claims, I also request payment of government benefits either to myself or to the party who accepts assignment.

OFFICE POLICY ON MANAGED CARE INSURERSaccommodate the needs of our patients. With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and who often they may be performed. Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, preventive care, hospitalization, and/or out patient procedures that are not covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Please check with your insurance provider if you have any questions relating to the services that we provide. We want you to receive all of the benefits offered to you.

<u>MEDICARE AND/OR MEDICAID RECIPIENTS</u>- I request that payments of authorized Medicare and/or Medicaid benefits be made on my behalf to **Madison Ridgeland Medical Clinic.** I authorize any holder of medical or other information to release to the Division of Medicare and/or Medicaid to determine these benefits payable for related services.

Privacy Statement

Patient Name:		
Address:		
City:	State:	Zip Code:
Date of Birth:	Social Security Number:	
1. I authorize Madison Ridgeland Medical Clinic to discl	ose the information from my record to (provide	e name of any authorized recipient(s):

2. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment from alcohol and drug abuse.

3. I understand that I have a right to revoke this authorization at any time by presenting my written revocation to **Madison Ridgeland Medical Clinic, 11 Professional Pkwy, Ridgeland, MS 39157.** I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If the authorization has been revoked, it will be terminated on the following date, event or condition.

If I fail to specify an expiration date, event or condition, this authorization will automatically expire in six (6) months.

4. I understand that I can refuse to sign this authorization. I need not sign this form to obtain treatment, payment or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may then no longer be protected by federal confidentiality rule. If I have questions about uses or disclosures of my health information, I can contact Madison Ridgeland Medical Clinic, 11 Professional Pkwy, Ridgeland, MS 39157.

Signature:

Date:

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Madison Ridgeland Medical Clinic** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Madison Ridgeland Medical Clinic**:

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Signature: ____

_____ Date: ____

Insurance Filing and the Law

Recent Federal laws addressing all insurance companies require that we submit every claim to an insurance company accurately, reporting the exact services performed and the exact reason for performing them. We are not allowed to change this information just so the claim can be paid by the insurance company. Our practice **MUST** abide by these new laws, and will submit all claims to all insurance companies in this manner.

Annual Examinations

As a commitment to your health, we recommend that every patient have an "annual exam" that allows us to evaluate your overall health picture while helping to check for unexpected problems or illnesses. During this visit, we will update your known conditions, as well as look for any new problems. Unless there is some major new finding during this annual examination, we must submit the service to your insurance company as an annual examination, which may not be paid by your insurance company. Along with the examination, your doctor might suggest that some "screening" tests be performed to allow him or her to get a better "picture" of your health. These services may also be considered non-covered by your insurance company, in which case you will be expected to pay for them yourself. Even if the results of these tests show some problem, we must submit these tests as a "screening" to your insurance company and cannot change the information on the claim just to receive payment for the services from the insurance company. We will be glad to work with you on payment plans for non-covered medical services, but these arrangements must be made in advance.

Non-Covered Services

Are Your Responsibility

Insurance companies do not pay for all medical services, even those that might be helpful to the patient. When a service is not covered by your insurance policy, you will be responsible for paying the bill.

We cannot change information on an insurance claim just so that the claim will be paid.

If you are unsure if a service is covered by your plan, please call your insurance company in advance to see if you are going to be responsible for the bill.

___ Date: ____



Name

Date

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main rea	son for	today's	visit:
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Other concerns:	
What are your health goals for the next year?	
Where were you getting your care before?	
In the past 2 weeks, have you been bothered by:	Little interest or pleasure in doing things? □ No □ Yes Feeling down, depressed or hopeless? □ No □ Yes

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

Unexplained weight loss / gain Cough / wheeze Swollen glands Unexplained fatigue / weakness Loud snoring / altered breathing during Easy bruising Fall asleep during day when sitting sleep No problems Fever, chills Short of breath with exertion Neurological No problems Gastrointestinal Headache New or change in mole Heartburn / reflux / indigestion Fainting Rash / itching Blood or change in bowel movement Dizziness No problems Onstipation Unexplained strugging No problems Onstipation Unexplained strugging	
Fall asleep during day when sitting sleep No problems Fever, chills Short of breath with exertion Neurological No problems No problems Neurological Skin Gastrointestinal Memory loss New or change in mole Heartburn / reflux / indigestion Fainting	
Fever, chills Short of breath with exertion No problems No problems Skin Gastrointestinal New or change in mole Heartburn / reflux / indigestion Rash / itching Blood or change in bowel movement No problems Dizziness No problems Numbness / tingling	
No problems No problems Neurological Skin Gastrointestinal Headache New or change in mole Heartburn / reflux / indigestion Fainting Rash / itching Blood or change in bowel movement Dizziness No problems Constipation Numbness / tingling	
Skin Gastrointestinal	
Skin Gastrointestinal Memory loss New or change in mole Heartburn / reflux / indigestion Fainting Rash / itching Blood or change in bowel movement Dizziness No problems Constipation Numbness / tingling	
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Rash / itching Blood or change in bowel movement Dizziness No problems Constipation Numbness / tingling	
Rash / itching Blood or change in bowel movement Dizziness No problems Constipation Numbness / tingling	
No problems Constipation Numbness / tingling	
Breast Frequent falls	
Breast lump / pain / nipple discharge Genitourinary No problems	
No problemsLeaking urine	
Blood in urine Allergic/Immune	
Ears/Nose/ThroatNighttime urination or increasedHay fever / allergies	
Nosebleeds, trouble swallowing frequencyFrequent infections	
Frequent sore throat, hoarseness Discharge: penis or vagina No problems	
Hearing loss / ringing in ears Concern with sexual function	
No problems Psychiatric	
Anxiety / stress / irritability	
Eyes MusculoskeletalSleep problem	
Change in vision / eye pain / redness Neck pain Lack of concentration	
No problems Back pain No problems	
Muscle / joint pain	
Cardiovascular No problems Women only	
Chest pain / discomfort Pre-menstrual symptoms (bloating	
Palpitations (fast or irregular heartbeat) Endocrine cramps, irritability)	
No problems Heat or cold sensitivity Problem with menstrual periods	
No problems Hot flashes / night sweats	
No problems	

IMMUNIZATIONS:	Check off any vaccinatio	ns you have had.	Add year,	if known. Check the	box if you don't know	the information.
Tetanus (Td)	_ With Pertussis (Tdap)	Varicella	(Chicken	Pox) shot or illness	Pneumovax (p	neumonia)
Influenza (flu shot)	Hepatitis A	Hepatitis B	MMR	Meningitis	Zostavax (shingles)	HPV

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date	Abnormal? DNo	□Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date	Polyp? □No	o⊓Yes
Women only:			
Mammogram	Date	Abnormal? □No	o⊡Yes
Pap Smear	Date	Abnormal? □No	o⊡Yes
Bone Density Test	Date	Abnormal? □No	o ⊡Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? DNNE

Condition	Current	Past	Comments
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn /GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			

PERSONAL MEDICAL HISTORY Continued: Condition	Current	Past	Comments
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications. DNONE

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery (lumbar)			
Biopsy (location)			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Colonoscopy			
Coronary Bypass / Stent			Circle: Bypass Stent
EGD (Stomach Endoscopy)			
Cataract			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (other than coronary bypass)			
Hip Surgery			Circle: Right Left Both
Hysterectomy (total, including ovaries)			Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: Surgical Procedure	Yes	Year	Comments
Knee Surgery			Circle: Right Left Both
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Ligation ("Tubal")			
Ovary Removal			Circle: Right Left Both
Vasectomy			
Sigmoidscopy			
Sinus Surgery			
Other (list)			

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY - Indicate which relative has had the following diseases (parents and siblings are most important).

	Mother	Father	Sister(s)	_	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad		
Disease					2	~			Other Relative	Comments
No significant history known										ļ
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease								1		
Kidney Disease	1					1		1		
Kidney Stones								1		
Macular Degeneration						1		1		
Migraine Headaches										
Osteoporosis										
Other (list)	1							1		

OTHER HEALTH ISSUES:

Tobacco Use

Smoke cigarettes: Never No Yes
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: \square Pipe \square Cigar \square Snuff \square Chew

Alcohol Use

Do you drink alcohol?
□ No □ Yes
of drinks/week: _____ □ Beer □ Wine □ Liquor

Drug Use

Do you use marijuana or recreational drugs? DN D Yes Have you ever used needles to inject drugs? NO D Yes

Sexual Activity

Sexually involved currently:
□ No □ Yes
Sexual partner(s) is/are/have been:
□ male □ female
Birth control method (circle below all that apply):
□ None needed
Condom, pill, diaphragm, vasectomy, other _____

SOCIAL HISTORY:

Exercise:

Do you exercise regularly? □ Yes □ No What kind of exercise? _____

How long (minutes)? _____ How often? _____

Diet:

How would you rate your diet? □Good □ Fair □ Poor Would you like advice on your diet? □No □ Yes

Safety:

Do you use a bike helmet? □No bike □Yes □No Do you use seatbelts consistently? □Yes □No Does your home have working smoke detectors? □Yes □No Is violence at home a concern for you? □Yes □No Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)? (Circle above all that apply) □ Yes □ No

Occupation (or prior occupation):	ret	tired/unemployed/leave of absence/disabled
(circle one) Employer:	Years of education or hig	ghest degree:
Marital status (circle one): single, partner,	married, divorced, widowed, other: _	
Spouse/partner's name: Number of grandchildren:		Ages if under 18 years:
Who lives at home with you?		
Leisure activities, group involvement, relig	ion, volunteer work, recent travel:	

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating:

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Thank-you for taking the time to fill this out.



Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: ____/ __/

Release of Information

[] I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released to:

[] Spouse	
[] Child(ren)_	
[] Other	

[] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [] my home [] my work [] my cell Number: ______ If unable to reach me:

[] you may leave a detailed message

[] please leave a message asking me to return your call

[]_____

The best time to reach me is (day)______ between (time)_____

Signed:	Date:	/	/	1
0				

Witness: Date	:/	_/
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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send a letter to:

Madison Ridgeland Medical Attn: Privacy Officer 11 Professional Parkway Ridgeland, MS 39157

By signing this form, you are only acknowledging that you have been provided our Notice.

Signature of Patient or Authorized Representative Date

Print Name of Patient/Authorized Representative

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used as necessary to support the day-today activities and management of Madison Ridgeland Medical Clinic. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed

• The right to receive a printed copy of this notice

Madison Ridgeland Medical Clinic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Geneva Love. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Geneva Love MRMC 11 Professional Parkway Ridgeland, MS 39157

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Geneva Love Madison Ridgeland Medical Clinic 11 Professional Parkway Ridgeland, MS 39157 (601) 856-2460

Effective Date 04/01/15



PRESCRIPTION GUIDELINES

Our goal at Madison Ridgeland Medical Clinic is to provide our patients with the best treatment possible in a pleasant and caring manner. The following prescription guidelines are intended for the safety of our patients:

- Medications should be taken as prescribed.
- Patients should first check with their pharmacy to verify if any refills are remaining.
- Pharmacies are asked to electronically request prescription refills. We do not take refills by phone or fax.
- Our office is available to refill prescriptions Monday Thursday, 8:30am to 4:00pm.
- Please allow 72 hours for all medication refills.
- Prescriptions will not be filled on the weekends or after hours.
- Some medications cannot be refilled after 3 months unless the patient has been seen and/or lab work has been done. No exceptions.



Notice to all patients of Indira Veerisetty, Kenneth Kaiser, Denise Shaw

Administrative Fees not covered by insurance. Payable only by cash or credit card.

Photocopies will be a \$0.50 per page charge.

Forms completion for any forms including but not limited to: School forms, disability forms, FMLA forms, life insurance forms, patients assistance forms, accident or worker's comp forms will be subject to a \$30.00 charge per form completed.

Refills requested outside an office visit. Any refills not requested at your appointment will be subject to a \$20.00 fee.

Phone Consults. Any patient-initiated calls to the doctors that lead to a diagnosis of a new problem or advice about an existing problem or recurrent problem will be subject to a \$30.00 fee.

No shows. Any appointments not canceled within 24 hours of the appointment time will be subject to a \$30.00 no show fee.