REDDY CARE
URGENT MEDICAL CENTER
A S REDDY, MD, FACEP

NEW: ___ CHANGE: ___ DATE: __/__/__

PATIENT

LAST NAME: ______________ FIRST NAME: ______________ MI: ___

ADDRESS: ______________ PHONE: ( ) -

CITY: ______________ STATE: ___ ZIP: ______

DATE OF BIRTH: __/__/__ SOC. SEC. #: ___-__-____ SEX: M F

EMPLOYER: ______________ PHONE: ( ) -

PERSON TO NOTIFY IN CASE OF EMERGENCY: ______________ PHONE: ( ) -

REFERRING PHYSICIAN: ______________

RESPONSIBLE PARTY

LAST NAME: ______________ FIRST NAME: ______________ MI: ___

ADDRESS: ______________ PHONE: ( ) -

CITY: ______________ STATE: ___ ZIP: ______

EMPLOYER: ______________ PHONE: ( ) -

PRIMARY INSURANCE

INSURANCE CARRIER: ______________ POLICY #: ______________

SUBSCRIBER'S LAST NAME: ______________ FIRST NAME: ______________ MI: ___

SUBSCRIBER'S ADDRESS: ______________ PHONE: ( ) -

CITY: ______________ STATE: ___ ZIP: ______

PATIENT'S RELATIONSHIP TO SUBSCRIBER: 1) SELF 2) SPOUSE 3) CHILD 4) OTHER

SUBSCRIBER'S EMPLOYER: ______________ SUBSCRIBER'S DATE OF BIRTH: __/__/__

SECONDARY INSURANCE

INSURANCE CARRIER: ______________ POLICY #: ______________

SUBSCRIBER'S LAST NAME: ______________ FIRST NAME: ______________ MI: ___

SUBSCRIBER'S ADDRESS: ______________ PHONE: ( ) -

CITY: ______________ STATE: ___ ZIP: ______

PATIENT'S RELATIONSHIP TO SUBSCRIBER: 1) SELF 2) SPOUSE 3) CHILD 4) OTHER

SUBSCRIBER'S EMPLOYER: ______________ SUBSCRIBER'S DATE OF BIRTH: __/__/__

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO REDDY CARE FOR SERVICES FURNISHED ME BY THIS PROVIDER.
I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, ITS AGENTS, AND/OR OTHER INSURANCE COMPANIES, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

BENEFICIARY SIGNATURE: ______________ DATE: __/__/__

Reddy Care Urgent Medical Center

6161 Transit Rd.
suite # 6
E.Amherst, NY 14051

List any ALLERGIES you have:

List any MEDICATIONS you take:

Year of your last TETANUS shot:

List any previous significant TRAUMA:

Indicate any SURGERIES you have had: ☐ NONE

☐ Appendix ☐ Hernia ☐ Uterus ☐ Heart
☐ Tonsils ☐ Gallbladder ☐ Tubes Tied
☐ List Other ______________________

Do YOU have any of the following medical problems?

☐ Diabetes ☐ Arthritis ☐ AIDS ☐ Asthma or Lung
☐ Heart ☐ Stroke ☐ Cancer ☐ High Blood Pressure
☐ List Other ______________________

Do any of the following medical problems run in your FAMILY?

☐ Diabetes ☐ Arthritis ☐ AIDS ☐ Asthma or Lung
☐ Heart ☐ Stroke ☐ Cancer ☐ High Blood Pressure
☐ List Other ______________________

Do you smoke? ☐ Yes ☐ No

Packs per day _____ For _____ Years

Do you drink alcohol? ☐ Yes ☐ No

Drinks per week _____

Do you take drugs not prescribed by a doctor? ☐ Yes ☐ No

Check any of the following that you have had RECENTLY

☐ Fever/chills ☐ Very tired
☐ Weight loss ☐ Weakness
☐ Eye pain ☐ Recent vision changes
☐ Drainage from eyes
☐ Ear pain

Check any of the following that you have had RECENTLY (cont.)

☐ Nasal congestion or bleeding
☐ Sore throat
☐ Chest pain ☐ Shortness of breath
☐ Heart palpitations ☐ Ankle swelling

☐ Cough ☐ Phlegm
☐ Wheezes ☐ Difficulty breathing
☐ Nausea ☐ Constipation
☐ Vomiting ☐ Abdominal pain
☐ Diarrhea ☐ Blood from bowels
☐ Pain when urinating ☐ Blood in urine
☐ Frequency of urination ☐ Flank pain

Male:

☐ Testicle pain ☐ Discharge from penis

Female:

☐ Last menstrual period _____ ☐ # of pregnancies _____
☐ Vaginal discharge ☐ # of childbirths _____

☐ Neck pain ☐ Arm pain
☐ Back pain ☐ Leg pain
☐ Rash ☐ Change in skin color
☐ Itching

Female:

☐ Breast pain ☐ Discharge from breast

☐ Headache ☐ Passing out
☐ Dizziness ☐ Seizures
☐ Numbness
☐ Depression ☐ Anxiety
☐ Hallucinations ☐ Suicidal thoughts
☐ Heat or cold intolerance ☐ Excessive urination
☐ Excessive thirst
☐ Bleed excessively ☐ Swollen glands
☐ Bruise easily
☐ Joint pain or swelling

Signature: ______________________

Date: ______________________

Reddy Care Urgent Medical Center

6161 Transit Rd. ~ East Amherst, NY 14051
phone 716-688 6161 ~ Fax 716-636 5084 ~ Email reddycare@yahoo..com

Prior to the service rendered:

I understand that payment is due at the time of service

I understand that I am financially responsible for the balance that is not paid or denied by my insurance .

I Understand that ReddyCare follows Government regulations concerning patient confidentialityof medical information.

I have been provided with a copy of HIPAA rules

I understand that any questions concerning the HIPAA regulations may be directed to Dr. Siva Reddy or Dr. Donald Jacob.

Signature:____________________

Date: ____________________

HIPAA Notice of Privacy Practices

Reddy Care Medical Center
6161 Transit Road – Suite 6
East Amherst, NY 14051
and | Phone: (716) 688-6161 ı to be valid

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will 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 health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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 use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us 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. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: SIVA REDDY Signature [redacted] Date 4-15-03