Kunjan P. Thakor, M.D., P.A.

WELCOME TO OUR PRACTICE!

We understand that your schedule is busy and that your time is valuable. We would like to inform you that effective as of April 1, 2017, the new policy will be as followed:

Office Hours: Our office is open Monday – Friday from 9:00AM to 4:00PM, with our clinic days on Tuesday and Friday. We are closed on Wednesdays.

Appointments: We see patients by appointment only. Please expect 30 to 45 minutes for a Follow Up visit and 45 minutes to 1 hour for New Patients.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. Please let us know if you will be more than 20 minutes late so that we can reschedule your appointment.

Lab Work/Medical Procedures: We do not draw lab work in our office and in some situations, insurance company requirements dictate that we send out lab work to your in-network laboratory. You may receive a bill from CPL, Quest Diagnostics, or LabCorp. Please contact their billing department prior to calling our office. We do not have access to their billing information.

Because of our limited number of available appointments each week, failure to have required lab work/medical procedures for your appointment may result in a **NONREFUNDABLE $25.00 FEE**, which will be collected at your next appointment. Please contact your laboratory if you are interested in setting up a reminder for lab work.

Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.
- If you need to call for refills, don't wait until you have run out. All refills require the doctor's approval. It may be the next day (or Monday) before it can be authorized.
- Don't go to the pharmacy to wait for your prescription to be called in. **Call them first to see if it is ready.**
- Refill requests called to us before 1:00 PM will be handled by the end of the day. After 1:00 PM., it may be the next morning before your request can be addressed.
- Some medications have potential side effects that must be monitored. We may require check-ups every 3 or 4 months for these medications. Be sure to keep those follow-up appointments.
- **Don't call after hours for prescription refills**. There is no access to your chart and we may not be able to help you.

Patients with IV Antibiotics

When on IV antibiotics, follow up appointments are necessary and weekly labs are required. If there are any issues with your PICC line or IV antibiotics, please call our office immediately to prevent any delays.

Mail Order Prescriptions: Many insurance plans offer financial incentives for using mail order pharmacies. We are glad to fax your prescription to your pharmacy or you are welcome to pick up the script from our office.

Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won't follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

ACKNOWLEDGEMENT OF REVIEW		
I acknowledge and accept the terms and conditions of the new office policy that is effective as of April 1, 2017		
_____	_____	_____
PRINT PATIENT NAME	***PATIENT/GUARDIAN SIGNATURE***	***DATE***

Kunjan P. Thakor, M.D., P.A.
Board Certified in Infectious Diseases

Medical History Questionnaire

Patient Name: _____Signature: _____ Date: _____

Pharmacy: _____ Pharmacy Phone: _____

Complaints & Symptoms:	Yes	No
Fever		
Fatigue		
Weight Loss		
Weight Gain		
Night Sweats		
Loss of Appetite		
Sedentary (Low Activity Level)		
Allergic/Immunologic:		
Rhinitis (Inflamed Nasal Passage)		
Hay Fever		
Seasonal Allergies		
Food Allergies		
Cardiovascular		
Dyspnea on exertion (Shortness of Breath with Activity)		
Edema (Swelling)		
Orthopnea (Shortness of Breath When Lying Down)		
Palpitations		
Intermittent Claudication (Pain on Extertion, i.e: walking to mailbox)		
Endocrine		
Polydipsia (Excessive Thirst)		
Polyuria (Excessive Urination)		
Heat Intolerance		
Cold Intolerance		
Eyes		
Blurred Vision		
Dry Eyes		
Vision Changes		
Genitourinary (GU)		
Pregnant		
Difficulty/Pain/Urination		
Blood in Urine		

Complaints & Symptoms:	Yes	No
Gastrointestinal (GI)		
Bowel Incontinence		
Jaundice		
Nausea/Vomiting/Diarrhea		
Loss of Appetite		
Integumentary(Hair/Skin/Nails)		
Pruritus (Severe Itching)		
Rash		
Skin Allergies		
Musculoskeletal		
Muscle Weakness		
Muscle Pain		
Neurology		
Headaches		
Numbness		
Dizziness		
Seizures		
Psychiatric		
Depression		
Anxiety		
Psychiatric problems		
Respiratory		
Pneumonia		
Pneumothorax (Collapsed Lung)		
Pulmonary Embolus (Blood Clot in Lung)		
Tuberculosis		
Upper Respiratory Infection		
Cough		
Skin/Breast		
Rash or Bruises Easily		
Breast Disease/Lumps		
Nipple Discharge		

Are you having any symptoms that you would like to discuss? –Please list them.

_____

_____

_____

_____

_____

5930 W. Parker Rd. ▪ Suite 600 ▪ Plano, TX 75093 ▪ (972) 378-3242 ▪ Fax: (972) 378-3206

Kunjan P. Thakor M.D., P.A.
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PAST MEDICAL HISTORY

PATIENT NAME:	DATE OF BIRTH:

DO YOU NOW OR HAVE EVER HAD:

❑ HIV/AIDS
❑ Lupus
❑ Reynaud's Disease
❑ Rheumatoid Arthritis

Cardiovascular
❑ Congestive Heart Failure
❑ Coronary Artery Disease
❑ Peripheral Vascular Disease
❑ Rheumatic Fever

Endocrine
❑ Gestational Diabetes
❑ Thyroid Disease
❑ Type 1 Diabetes (Insulin Dependent)
❑ Type 2 Diabetes (Adult-Onset)

Neurology
❑ Stroke
❑ Multiple Sclerosis

Eyes
❑ Retinopathy (Damage to Eyes)

Ear/Nose/Mouth/Throat
❑ Sinusitis

Musculoskeletal
❑ Osteomyelitis
❑ Osteoarthritis

Respiratory
❑ Pneumonia
❑ Positive TB
❑ Upper Respiratory
❑ Pulmonary Embolus (Blood Clot in Lung)

Gastrointestinal (GI)
❑ Cohn's Disease
❑ Hepatitis (Liver Infection)
❑ Ulcerative Colitis

Oncologic
❑ Cancer:_____

Integumentary(Hair/Skin/Nails)
❑ Pruritus (Severe Itching)
❑ Skin Allergies
❑ Rash

Genitourinary (GU)
❑ Kidney Disease
❑ Prostate Cancer
❑ Sexually Transmitted Diseases:
_____

Psychiatric
❑ Alzheimer's
❑ Dementia
❑ Depression

Other Conditions:
_____
_____
_____

SOCIAL HISTORY

Alcohol Abuse: ❑ No ❑ Yes Describe:

Caffeine Use: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Tobacco Use: ❑ Never ❑ Previously ❑ Less 1/pack
❑ Greater than 1 Pack – #:

Illicit Drug Use: ❑ Never ❑ Previously ❑ Currently

Type /Frequency:

THE LAST TIME YOU HAD A – (Year)

Flu Vaccine		Tetanus Shot	
Hepatitis Vaccine		Pneumonia Shot	
T.B Test		Other	

HOSPITALIZATION

Please list any major surgeries or operations that you have had.

Year	Surgery/Operation

FAMILY HISTORY

Please list any major illness in siblings, parents, or grandparents:
_____
_____
_____

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MEDICATION LIST

NAME:	**DATE OF BIRTH:**
ALLERGIES:	

❑ **See attached medication list.**

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

NAME OF MEDICATION	DOSES & AMOUNT PER DAY	HOW LONG HAVE YOU BEEN TAKING THIS?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

KUNJAN P. THAKOR M.D., P.A.
REGISTRATION FORM

(Please Print Information)

PCP:

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE:	❑ Mr. ❑ Ms. ❑ Mrs. ❑ Miss

MARITAL STATUS: (Circle One)	BIRTH DATE:	AGE:	SEX:
Single / Married / Divorced / Separated / Widow	/ /		❑ M ❑ F

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

PERFERRED PHONE #: ❑ Home ❑Cell ❑Work ❑Other:_____	ALT #: ❑ Home ❑Cell ❑Work ❑Other:_____
( )	( )

OCCUPATION:	EMPLOYER:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY INSURANCE:	INSURANCE PHONE NUMBER:

POLICY NUMBER:	GROUP NUMBER:

OCCUPATION:	EMPLOYER:

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER: _____

SUBSCRIBER'S NAME:	BIRTH DATE:	ADDRESS (If Different):
	/ /	

SECONDARY INSURANCE (If Applicable):	INSURANCE PHONE NUMBER:

POLICY NUMBER:	GROUP NUMBER:

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER: _____

WORKERS COMP ONLY

COMPANY/EMPLOYER NAME:	CLAIM #:

ADJUSTER NAME:	ADJUSTER PHONE #:	DATE OF INJURY:
	( )	

SIGNATURE OF ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize KUNJAN P. THAKOR M.D., P.A. or insurance company to release any information required to process my claims.

_____ _____

PATIENT/GUARDIAN SIGNATURE ***DATE***

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AUTHORIZATION FOR RELEASE OF CLINICAL RECORDS

PATIENT NAME:	**DATE OF BIRTH:**

PLEASE INITIAL YOUR AUTHORIZATION AND SIGN AT THE BOTTOM:

_____ I *DO NOT* wish to authorize any members at this time.

_____ I hereby AUTHORIZE the following members to have authorization to be given my health information:

Name: (Please Print)	**Relation to Patient:**	**Phone:**

This request and authorization applies to:

❑ All Healthcare Information

❑ Healthcare information relating to the following treatment, condition, or dates: _____
_____

❑ Appointment Times

❑ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ Yes ❑ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ Yes ❑ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that if the recipient authorized to receive the health information is not a covered entity (e.g. insurance company or non-health care provider); the release information may no longer be protected by federal and state privacy regulations.

I understand that this authorization is voluntary and acknowledge the fact that I may revoke this authorization at any time, provided that I do so in writing and submit it to the office of Kunjan P. Thakor M.D. P.A.

_____ _____
PATIENT SIGNATURE ***DATE***

_____ _____ _____ _____
PRINT LEGAL REPRESENTATIVE NAME ***LEGAL REPRESENTATIVE SIGNATURE*** ***DATE*** ***RELATIONSHIP TO PATIENT***

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AUTHORIZATION FOR RELEASE OF INFORMATION FROM OTHER MEDICAL FACILITIES

PATIENT NAME:	**DATE OF BIRTH:**

This form is a requirement for our office so we are able to receive medical records and any other necessary documents from other medical facilities.

If you DO NOT wish to authorize the office at this time to request and receive your records,
please leave this form blank.

❑ Consultation Reports	❑ List of All Medications	❑ Hepatitis Information	❑ Test Results (Labs, X-Rays, etc)
❑ Discharge Summary	❑ Mental Health/Alcohol and Drug Abuse Treatment	❑ History and Physical Exams	❑ All of the Above
❑ Progress Notes	❑ Statement of Charges and Payment	❑ AIDS or HIV Information	

The purpose of the disclosure:

❑ Request of Individual	❑ Change of Doctor	❑ Legal Investigation
❑ Referral to Specialist	❑ Insurance	❑ Other: (Please Specify)
❑ Continuing Care	❑ Workers Comp	

I understand that my medical information may include sensitive health information. Communicable diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), if diagnosed, will be included in my medical records. I further understand that my medical information could indicate that I am undergoing treatment for psychological or psychiatric conditions or substance abuse.

I understand that I may revoke this authorization **in writing at any time**, except to the extent that the office of Kunjan P. Thakor has already relied on this authorization. The written revocation should be addressed to the office of Kunjan P. Thakor. Unless otherwise revoked, I understand that the date or event upon which this authorization *expires* is one year from the date of signature. A copy of this authorization is considered as valid as the original.

I understand that if the recipient authorized to receive the health information is not a covered entity (e.g. insurance company or non-health care provider); the release information may no longer be protected by federal and state privacy regulations.

I understand that Kunjan P. Thakor will not condition treatment, payment, enrollment or eligibility for benefits upon obtaining of this form. I understand I may be charged retrieval/processing fee and for copies of medical records according to Texas Hospital Licensing Law.

_____ _____
PATIENT SIGNATURE ***DATE***

_____ _____ _____ _____
PRINT LEGAL REPRESENTATIVE NAME ***LEGAL REPRESENTATIVE SIGNATURE*** ***DATE*** ***RELATIONSHIP TO PATIENT***

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Patient Consent Form / Acknowledgement of Review

I understand that as part of my healthcare Kunjan P. Thakor M.D. P.A. ("Physician") originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The (Physician's) Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been **provided a copy of OR access to the Notice of Privacy Practices** and understand that I have the right to review the notice prior to signing this consent. I understand that the (Physician) reserves the right to change the Notice of Privacy Practices. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the (Physician) is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the (Physician) has already taken action in reliance on my prior consent. **This consent is valid until revoked by me in writing.**

I request the following restrictions on the use and/or disclosure of my personal health information:
(e.g.: no media release, please send billing information to a different address.)

_____
_____
_____
_____
_____
_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

_____	_____	_____
PRINT PATIENT NAME	***PATIENT SIGNATURE***	***DATE***

_____	_____	_____	_____
PRINT LEGAL REPRESENTATIVE NAME	***LEGAL REPRESENTATIVE SIGNATURE***	***DATE***	***RELATIONSHIP TO PATIENT***

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Financial Policies

We are committed to providing you with the best possible care and your treatment being successful. Your clear understanding that payment of your bills is considered part of your treatment. Our relationship is with you and **NOT** with your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY** from the date of service rendered.

- If your insurance company only pays a portion of the bill amount or has rejected a claim, then **you will be responsible for any payment in full.** Reduction or rejection of your claim **does not relieve you from any and/or all financial obligation.**

- The copay is due at the time of service. **If you do not pay the copy or do not pay in full within 5-10 days from the date of service, you will be charged a nonrefundable fee of $10.00.**

- Any checks that are returned (bounced) are subjected to a **nonrefundable fee of $25.00** and will not be able to make any future appointments until any debt is paid in full.

- We will bill your health insurance for all services provided in the hospital and in the office. Any outstanding balances older than 30 days will be charged a fee of **$15.00,** more than 60 days will be charged a fee of **$25.00**, more than 90 days will be charged a fee of **$35.00**. Anything older than 90 days or noncompliance will be subjected to notification of a collection agency. **We strongly encourage any financial obligations be handled in a timely manner.**

- If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and copayments are due when services are rendered. If we **do not participate with your insurance company**, then payment must be **paid in full at the time of service. It is your responsibility to obtain a valid in or out-of-network referral from your primary care physician before your scheduled visit.**

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Accounts Manager.

Worker's Compensation: If your injury is due to an accident in your work place, please inform the receptionist immediately. It is your responsibility to contact your adjuster and provide us with the necessary information so we can process the claim

Liability Injury: If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance but will provide you with a receipt to do so.

Auto Accident: If your injury is a result of an auto accident, you are required to pay for services and then collect from the auto carrier. We will not file your insurance but will provide you with a receipt to do so.

Medical Records: We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. **Please allow up to 30 days for this request to be processed.**

I acknowledge that I have read and understand the policies stated above. I hereby assign Kunjan P. Thakor M.D. P.A. all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Kunjan P. Thakor M.D. P.A. to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during and after my treatment with Kunjan P. Thakor M.D. P.A. This assignment will remain effective until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I also understand and agree that such terms may be amended from time to time by the practice.

_____	_____	_____
PRINT PATIENT NAME	***PATIENT SIGNATURE***	***DATE***

_____	_____	_____	_____
PRINT LEGAL REPRESENTATIVE NAME	***LEGAL REPRESENTATIVE SIGNATURE***	***DATE***	***RELATIONSHIP TO PATIENT***