GULATI AND ASSOCIATES, PA

Manjit Singh Gulati, M.D., FASN

Patient Registration

Patient name _____ Male _____ Female _____

SS#_____ Date of Birth_____ Married_____ Single_____ other___

Address_____ Zip_____

Home Phone_____ Cell Phone_____

Patient e-mail address_____

Race: Asian___ African American___ Pacific Islander___ White___ Other___ Decline ___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___

Primary Care Physician Name _____Phone_____

Pharmacy_____Phone_____

Emergency contact_____ Phone number_____

Relationship_____

How did you learn about Gulati and Associates, PA: Friend/Family___ Internet___ Insurance___

Doctor Referral _____

How will you be paying for today's bill? Self-pay__ Insurance__ Worker's compensation claim__

I will be paying the full bill/ co-pay today using: Cash__ Debit card__ Credit card__ Check__

Insurance Primary Policy Holder_____

Information: Member ID_____ SS#_____ DOB_____

Relationship to subscriber: Self___ Spouse ___ Child ___Other___

Do you have insurance with more than one Health Plan? Yes___ No___

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Financial Policy

Insurance: Insurance is a contract between you and your insurance. We are NOT a party to this contract, in most cases. We will bill primary and secondary contracted insurance companies only. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. Payment option if you have NO insurance or insurance company we DO NOT accept: You choose to pay by Cash, Credit, Debit card or Check the day services are rendered. I hereby authorize direct payment of medical benefits to Gulati and Associates, PA for activities rendered by the physician. I understand that I am financially responsible for any balance not covered by insurance. I certify that I am responsible for health insurance co-pay and co-insurance. I certify that all information is correct and authorize Gulati and Associates, PA to release any information for either medical care or in processing application for financial benefits. By executing this agreement, you are agreeing to pay for all services that are rendered.

Patients name (please print)_____

Responsible party (If not patient):_____

Signature_____ Date_____

Notice of Privacy Practices: I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my health information.

Patient's name (please print) _____

Signature_____ Date_____

Medical record release:

I, _____, hereby authorize release of my medical record information to my primary care Physician or any other Physician upon request. I understand that this authorization may be revoked at any time.

Signature_____ Date_____