



West Horizon Medical Center

1601 N. Tucson Blvd, Ste 18 Tucson AZ 85716

Tel: (520) 622-7675 Fax: (877) 870-9161

Patient Name: _____
Last First Middle

Permanent Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: ____/____/____ Age: ____ Race: _____
Month Day Year

SS Number: _____ Sex: Male / Female / _____

Drivers License Number: _____ **State:** _____

Marital Status: Single / Married / Widowed / Divorced

In Case of Emergency: Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Default Pharmacy: (Name/Address) _____

CONSENT TO TREATMENT: I hereby grant my authorization and consent to ongoing routine treatment and procedures for the below named patient by West Horizon Medical Center. I hereby grant West Horizon Medical Center permission to view Rx Prescription history from any external sources.

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to West Horizon Medical Center.

RELEASE OF INFORMATION: I authorize West Horizon Medical Center to release information to my insurance carrier, which may be required in the processing of a claim for coverage.

Signature: _____ **Today's Date:** _____



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Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them, and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. To protect your privacy, we need your written permission to leave detailed telephone messages on your answering machine, voice mail system or with a trusted family member. It should be noted that our current notice of privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s). Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it.

Please choose one of the following:

I DO CONSENT for West Horizon Medical Center, PC and his staff to leave detailed messages: I, _____ give West Horizon Medical Center, PC permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

Answering machine _____ Initials _____

My cell phone _____ Initials _____

Spouse (name) _____

Phone number(s) _____ Initials _____

Other (name) _____

Phone number(s) _____ Initials _____

Patient Signature Today's Date

Patient Print Name Date of Birth

If not signed by patient, please indicate your relationship to the patient _____

Print Patient Name: _____ Date of Birth _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & PARTNERSHIP AGREEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of West Horizon medical Center, PC Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

STATEMENT OF PARTNERSHIP: By signing below, I accept **Dr. Surekha Bandlamuri, MD** of West Horizon Medical Center as my healthcare partner and advisor. If I **do NOT** choose to follow her instructions or advice, I understand that I am responsible for any consequences.

Patient Signature

Today's Date

Patient Print Name

Date of Birth



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Financial Agreement

Payments (co-payments, co-insurance and / or deductibles) are due at the time of your medical services at West Horizon Medical Center (WHMC) unless other arrangements have been made with our billing office.

As a courtesy we will bill your medical insurance plans. However, as a patient, it is your responsibility to understand your benefits (i.e. deductibles, co-insurance, maximums, health saving accounts [HAS], benefit exclusions and limitation plans). Please be advised that we will work with you for the best of our abilities. You will be responsible for any amount not covered by your insurance.

We reserve time for each patient based on your appointment date and time. There will be a **\$40** billed to your account if you fail to cancel your appointment within **48 hours** of your scheduled appointment.

There will be a fee of **\$50** for each not sufficient funds check (NSF) submitted by you and returned by your bank.

All patient portions are due upon the conclusion of your visit / medical services at WHMC. For the remaining patient portion, our billing department will send you an account statement and your payment is due upon receipt of the statement.

It is the responsibility of the patient to make certain that all medical services including labs/tests, imaging, referrals and Rx medications rendered by our providers are in-network of your insurance carrier. Please verify with your insurance carrier to verify coverage before utilizing any medical service.

For all patient balances that are older than **90 days** there will be late charge of **10%** added to the balance of your account

I read and understand the above-mentioned financial agreement with West Horizon Medical Center

Patient Signature

Today's Date

Patient Print Name

Date of Birth



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Authorization to Release Medical Information

I hereby authorize

Doctors Name _____

Doctors Address _____

Doctors Telephone _____

Doctors Fax _____

To divulge and release my entire medical chart to

Surekha Bandlamuri, MD
West Horizon Medical Center
1601 N. Tucson Blvd, Ste 18
Tucson, AZ 85716
Tel: (520) 622-7675 Fax: (877) 870-9161

I authorize the release of my complete medical chart (records) to West Horizon Medical Center. This authorization includes progress notes, labs, imaging test results, Rx, drug and alcohol abuse, mental health, Diagnosis / Treatment of HIV, HIV-related illness, AIDS, AIDS-related illness and communicable disease related information.

To be filled by Patient or Responsible Party

Patient Signature Today's Date

Patient Print Name Date of Birth

**We prefer to receive medical records in electronic format
(CCD File) on (CD/DVD) as we use eClinicalWorks EMR.**