New Patient Information Sheet

Patient Name:_____ D.O.B:_____ Age:____

If you are here following an accident or auto injury and want to be examined for that purpose to make claims, please inform us right now, so that we can refer you to another facility for proper guidance.(We do not do examination for the purpose of making legal/Accident claims and we do not provide our records to any Attorney's for those purpose.)

Main Reason for Today's Visit:

Problem(s):

_____

_____

Allergies: Medication_____

Food_____

PAST MEDICAL HISTORY: Have you had any of the following?**(Circle YES or NO)**

Heart disease	(Yes)	(No)	Cancer	(Yes)	(No)
High blood pressure	(Yes)	(No)	Stomach problem	(Yes)	(No)
High blood sugar(diabetes)	(Yes)	(No)	Hepatitis	(Yes)	(No)
Stroke	(Yes)	(No)	Prostrate problem	(Yes)	(No)
Lung problem	(Yes)	(No)	Urinary/Bladder	(Yes)	(No)
Asthma	(Yes)	(No)	Depression/anxiety	(Yes)	(No)
High cholesterol	(Yes)	(No)	Arthritis	(Yes)	(No)
Thyroid problem	(Yes)	(No)	Vision/Hearing	(Yes)	(No)
Significant Weight Loss	(Yes)	(No)	Loss of Appetite	(Yes)	(No)

Other Medical Problems(**Or details apart from the above**):

_____

_____

PLEASE LIST YOUR SURGERIES (If any)

SURGERY	***YEAR***	***SURGERY***	***YEAR***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications if Taken: ☐ **None at all** ☐ **Listed Below:**

MEDICATION NAME	***DOSAGE***	***TIMES PER DAY***	***WHEN STARTED***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Has any of your family member(including **parents, grandparents and siblings**) ever had any of the following?

Which family member?

Heart disease _____

Hypertension _____

Diabetes _____

Stroke _____

Cancer(describe type)_____ _____

Other_____ _____

Social History:

Are you: **Single**_____**Married**_____**Divorced**_____**Widowed**_____# of Children_____

Occupation_____How long in this Occupation?_____

Do you Smoke? (No) (Yes) How many packs?_____ How many years?_____
Quit smoking?_____ When?_____

Do you Drink alcohol? (No) (Yes) How often?_____ How many years?_____
Quit drinking?_____ When?_____

Do you use Street/Illicit drugs? (No) (Yes) What kind?_____ Any IV drugs?_____
Quit drugs?_____ When?_____

Where you exposed to Chemicals/Hazardous material? (No) (Yes) What type?_____When?_____
Any Health disorder from exposure and type?
_____

Do you exercise rountinely? (No) (Yes) Duration per day_____ Times per week_____

Do you a have any Living will/ Advanced directives regarding Health? (No) (Yes) (If yes please provide with copy)

Do you have a Durable Power of Attorney regarding health decisions? (No) (Yes) Who?_____
Relationship_____

Authorization/Financial Responsibility/Privacy Policy

I acknowledge that I have financial responsibility for payment of all services rendered (even if I have health insurance paying a portion). **I am responsible for any charges my insurance carrier declines*. I fully understand, that it is my responsibility to check what benefits are covered and not covered by my insurance. I also fully understand, that it is my full responsibility to provide complete and accurate details of my personal information and insurance details.*** If insurance is submitted for me (or for my dependants), I hereby authorize payment of medical benefits directly to your office for services rendered. I further authorize release of any medical information necessary to process any and all claims for submittal to my insurance carriers, if applicable**. I hereby acknowledge that it is my responsibility to obtain any required referral or treatment authorizations from my insurance providers**. **I accept responsibility for all costs incurred in my treatment if I fail to provide accurate insurance information.** ***I also accept responsibility and agree to pay the full costs for the services provided to me, if my Insurance denies the payment or only pays partial amount.*** I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment directly to CANYON MEDICAL CENTER on my behalf for any services and materials furnished. I authorize CANYON MEDICAL CENTER to release to my insurance company any information required to determine eligibility for benefits or to receive payment for services rendered.

PRIVACY POLICY: The most common reason why we use or disclose your health information is for treatment, payment or health care operations. We may call or write to remind you of scheduled appointments or write to notify you of other treatments or services available at our office. We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. I understand I may request to read the full text of our privacy policy at any time. I acknowledge that I have received notice of CANYON MEDICAL CENTER Privacy Practices.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name: Last First

Today's Date: _____

Patient's Demographic & Insurance details

Name of Patient: _____

Date of Birth: _____/_____/_____ **Age:**_____ **Gender: Male / Female** **SSN:** _____

Address: _____

_____ **E-mail:**_____

Home Phone#: _____ **Work/Day Phone#:** _____

Primary Insurance Name: _____ Co-payment : $_____

Primary Insurance ID#: _____

Primary Insurance Address & Phone Number:_____

_____

Primary Insurance Guarantor: _____

Secondary Insurance Name: _____

Secondary Insurance ID# : _____

*Secondary Insurance Address & Phone#*_____

Patient's Occupation:_____ Patient's Employer: _____

Emergency Contact Name & Phone # :

ASSIGNMENT: *I, the undersigned, certify that I, or my dependent, have insurance coverage with the company(s) listed above. I assign all insurance benefits directly to R.MUTHAIAH M.D / CANYON MEDICAL CENTER I understand that I am financially responsible for all charges whether or not paid by insurance.I acknowledge that I have financial responsibility for payment of all services rendered (even if I have health insurance paying a portion).* ***I am responsible for any charges my insurance carrier declines.*** *I fully understand, that it is my responsibility to check what benefits are covered and not covered by my insurance. I also fully understand, that it is my full responsibility to provide complete and accurate details of my personal information and insurance details. If insurance is submitted for me (or for my dependants), I hereby authorize payment of medical benefits directly to your office for services rendered. I further authorize release of any medical information necessary to process any and all claims for submittal to my insurance carriers, if applicable. I hereby acknowledge that it is my responsibility to obtain any required referral or treatment authorizations from my insurance providers. I accept responsibility for all costs incurred in my treatment if I fail to provide accurate insurance information. I also accept responsibility and agree to pay the full costs for the services provided to me, if my Insurance denies the payment or only pays partial amount. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment directly to R.MUTHAIAH M.D / CANYON MEDICAL CENTER on my behalf for any services and materials furnished. I authorize R.MUTHAIAH M.D / CANYON MEDICAL CENTER to release to my insurance company any information required to determine eligibility for benefits or to receive payment for services rendered.* ***Canyon Medical Center tries its sincere best to adhere to the appointment time. Sometimes due to the need for the Doctor/Doctors to attend to emergency scenario with other patients, either in the clinic or at hospital, or secondary to the availability of the Doctor, my appointment could be delayed or even cancelled. I am agreeing to accommodate and accept those unavoidable delays and cancellations; during those circumstances. I also fully understand and agree that, if I have a balance amount due, I will pay it promptly within 30 days time and if not my further appointments and services could be cancelled and the balance due could be sent to collection agency for further collection and recovery.***

PRIVACY POLICY: *The most common reason why we use or disclose your health information is for treatment, payment or health care operations. We may call or write to remind you of scheduled appointments or write to notify you of other treatments or services available at our office. We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. I understand I may request to read the full text of our privacy policy at any time. I acknowledge that I have received notice of R. MUTHAIAH M.D / CANYON MEDICAL CENTER Privacy Practices.*

APPOINTMENT CANCELATION NOTICE: If you are going to cancel your appointment please do it 48 hours prior to your visit. There will be a **$25 fee** for a late cancelation notice. There is **$15 fee** for requests to complete FMLA, Life, Disability and various other types of independent health forms.

I acknowledge that, the services are provided at Canyon Medical Center, in a non-emergency basis and if I have any life threatening medical emergency, I have to call 911 and go to the nearest ER. I also agree and acknowledge that, if I haven't seen the doctor with appointment and evaluation within 60 to 90 days; my prescriptions will not be refilled.

_____ _____

Signature of Patient/Responsible Party Date

_____

Last Name First Name

If your insurance or any of the information given above changes; please inform us immediately. Co-payments and Co-insurances are due at the time, the services are being provided; Please pay us promptly; Thank you for your co-operation.

MUTUAL BINDING ARBITRATION AGREEMENT

Patient's Name: _____

This mutual binding arbitration agreement constitutes an integral part of a contract for medical

services by and between Dr. R. Muthaiah M.D / R. Muthaiah MD PC and

_____

(name of patient) who agree to be bound as described hereunder:

1. It is under stood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided in Nevada law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. Such arbitration shall be in accordance with the arbitration rules of the Nevada Revised Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care or medical services rendered, whether inpatient or outpatient, against Dr. R. Muthaiah or any of Dr. R. Muthaiah's / R. Muthaiah MD PC employees or contracted staff.

3. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Dr. R. Muthaiah / R. Muthaiah MD PC. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.

4. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Date: _____ Time: _____ A.M./P.M.

Signature: _____

(patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: _____