Dr. Krishna Kakani
Gynecology
699 Gallatin St SW, Ste B1
Huntsville, AL 35801
Phone: (256) 251-5121 Fax: (256) 469-6061

(All Fields are Required - Please Print and Write Legibly)

Today's Date: _____ Primary Care Physician: _____

PATIENT DEMOGRAPHICS

Last Name: First Name: MI:	Date of Birth:	Social Security #:	Marital Status:
Street Address: City: State: Zip Code:			

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Cell Phone Carrier:	Text Message Authorization: Y or N	Preferred Method of Contact:
Occupation:	Employer:	Employer Phone #:

Primary Language:	Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Prefer Not to Answer	Race:

Emergency Contact Name:	Relationship to Patient:	Primary Contact #:	Alternate Contact #:

INSURANCE INFORMATION

Primary Insurance:			
Policy/Contact/Member # or ID:	Group #:	Subscriber Name:	Subscriber DOB:
Patient's Relationship to Subscriber:		Subscriber SS#:	
Secondary Insurance:			
Policy/Contact/Member # or ID:	Group #:	Subscriber Name:	Subscriber DOB:
Patient's Relationship to Subscriber:		Subscriber SS#:	

****Only Fill Below Section if Financially Responsible Party is Different from Self****

Person Financially Responsible for Account:		
DOB:	Address:	Phone #:
Employer:	Employer Address:	Employer Phone #:

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Kakani OB/GYN or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____

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Insurance Information Regarding Annual Appointments

Dr. Kakani's office complies with insurance coding guidelines from the American Medical Association (AMA). At your visit today, your provider will provide a medical service and submit codes to your insurance company according to the guidelines mandated by the AMA. We would like to share with you a clear explanation of the difference between an "Annual Exam Visit" and a "problem visit."

Please understand it is our goal to provide you with the best medical care while adhering to and making you aware of insurance guidelines.

Annual Exam Visit (aka Well Woman Visit)

- An annual exam is preventative annual care without any medical problems
- Visit generally consists of a pelvic exam, pap smear (if applicable), and breast exam (if applicable)
- You are allowed refills of yearly medications and mammogram orders as part of an annual visit
- Most insurances do not require a copay for an annual exam as long as it has been at least a year and a day since your previous annual exam
- If there are any issues or concerns you would like to discuss with your provider, please do not hesitate to do so. However, please be aware that your visit is then considered a "problem visit" and will be billed/coded accordingly. All codes and diagnoses are generated by your provider at the time of service in accordance with national standards set by the AMA.

Problem Visit

- A "problem visit" is any office visit that goes beyond the scope of an annual exam
- Visits such as medication follow ups, test result follow ups, imaging report follow ups, etc. are also considered problem visits and will be subject to copays
- Most insurance companies **do** require a copay for problem visits, which is due at the time of check-in
- If an annual visit becomes a problem visit during the course of the appointment, any applicable copay will be collected upon check-out

I certify that I have read and fully understand the above information and any questions or clarifications I have regarding the above information have been answered or explained to me by staff.

Patient/Guardian Signature: _____ Date: _____

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PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, surgery, and medical services performed by the staff of Kakani OB/GYN. These may include but are not limited to: emergency treatment of services, laboratory procedures, x-ray examinations, medical treatment, procedures, or anesthesia provided to me under the general and special instructions of my physician and/or surgeon.

FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorize and consent to my insurance benefits being paid directly to Kakani OB/GYN. I understand that I may have financial responsibility for all of or a portion of the charges for professional services rendered and will remit appropriate payment at the time of service, specifically including co-payments, deductibles, and charges for services not covered by my insurance. I understand if my account is delinquent for more than ninety (90) days, it may be transferred to a collections agency, and any fees associated will be added to my account.

COPAYMENT/DEDUCTIBLE POLICY: I understand that, if applicable at time of check in, I will be required to pay my co-payment and/or deductible set by my insurance. If I am unable to pay my required fee, I understand that prior arrangements must be made with the Billing Manager before my appointment. Any returned checks are subject to a $40.00 processing fee.

INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations of benefits of my insurance or health plan. I understand that if I have any questions regarding benefits or coverage, I will contact my insurance carrier/health plan.

REFERRALS/AUTHORIZATIONS: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. If so, and if my provider deems the referral medically necessary, I will allow 7-10 business days for this process. I will be promptly advised of any requests deemed not appropriate or medically necessary. I understand that if I choose to access specialty services without referral from my provider, or elect to use Point of Service option, if I fail to notify Kakani OB/GYN, or if my insurance requires specific outside vendors such as laboratories or imaging centers to perform services, I may be financially responsible for the full cost of services rendered and my insurance may not cover/reimburse me for the relevant services.

ANCILLARY SERVICES: I understand that depending on my insurance, I may receive a separate bill for any laboratory, x-ray, anesthesia, or other ancillary services.

RELEASE OF INFORMATION: I authorize and consent to the release of my medical records or other information necessary to provide health care, process medical claims, and other purposes related to health operations to outside vendors (such as laboratories, imaging centers, pharmacies, and other vendors responsible for the handling of my care).

RECORDS RELEASE FEES: I understand that any requests for the release of medical records (excluding to another doctor's office) will be subject to a $5.00 search fee plus $1.00 per page for the first 25 pages and $0.50 per page for each subsequent page past 25, plus any postage fees if mailing. I agree to pay these fees in advance, upon request. I understand it may take at least 24-48 hours to process these requests.

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MISC. FORM FEES: I understand that any forms requested to be completed by my physician that are not directly related to patient care will be subject to a $30.00 paperwork fee for the first set of forms, and a $15.00 paperwork fee for any subsequent forms. I agree to pay these fees in advance, upon request. Such forms include but are not limited to: jury duty forms, Family Medical Leave Act (FMLA) applications, accident reports, or school/camp forms.

ON-TIME ARRIVAL POLICY: I understand that it is strongly advised that I arrive at least 15 minutes before my scheduled appointment time in order to complete any necessary paperwork. I understand that if I arrive more than 15 minutes past my scheduled appointment time, I will have to reschedule unless I have made arrangements with staff prior to my appointment time. Our providers strive to maintain an "on-time" schedule, but I understand that urgent/complex needs of patients scheduled before me may cause my provider to be late for my appointment.

MEDICATION REFILL POLICY: I understand that refills may take 24-48 hours to process and the most efficient way of getting a refill is to contact my pharmacy directly. In order to ensure accurate and timely medication refills, I agree to notify Kakani OB/GYN of my preferred pharmacy. I understand that any medication refills requested outside of a scheduled appointment are subject to a $15.00 call-in fee. I agree to pay this fee in advance, upon request.

I certify that I have read and fully understand the above policies and any questions or clarifications I have regarding the above policies have been answered or explained to me by staff.

Patient/Guardian Signature: _____ **Date:** _____

DUE TO THE PRIVACY/CONFIDENTIALITY ACT:
Please check whether or not we have permission to leave voicemails/other notifications regarding lab/imaging/test results or other information in the event you do not answer.

_____ Yes, I consent to receiving voicemails/other notifications

_____ No, I do not consent to receiving voicemails/other notifications
*We will only leave a voicemail asking you to call the office back

Please list any person(s) that you authorize to have access to your protected health information and circle what information they may have access to:

Name of Person: _____ Relation: _____

Appointment Billing Medical Records

Name of Person: _____ Relation: _____

Appointment Billing Medical Records