ACE HEALTH AND WELLNESS CENTER PLLC

Internal Medicine Clinic *"Your health is our priority"*

Isha Gupta MD Jujhar Singh DO Srinivasa Reddy MD,MRCP

Patient Information

FIRST NAME:___________________________**MI:**_____**LAST NAME:** __________________

DOB: ______/______/__________ **SSN#**------------------------- _______

ADDRESS:____

CITY_______________________________**STATE:**_________**ZIP:**_______________________

MAILING ADDRESS:____

HOME PHONE: (_______**)**______**-**________**CELL PHONE: (**______**)**______**-**__________

EMAIL:____

PREFERRED METHOD OF CONTACT: HOME CELL EMAIL

SEX: MALE_______**FEMALE:**________

MARRIED:______**DIVORCED:**______**SINGLE:**______**SEPERATED**_____**WIDOW**_______

ETHNICITY: HISPANIC/LATINO:_____**NOT HISPANIC:**_____**REFUSED TO RESPOND**_____

RACE: WHITE__________**AFRICAN AMERICAN:**__________**ASIAN:**____________
AMERICAN INDIAN/ALASKA:________**NATIVE HAWAIIAN:**________**OTHER:**_________

LANGUAGE: ENGLISH:______**SPANISH:**_____**OTHER:** _____**SPECIFY:** ______________

LOCAL PHARMACY:_________________**PHARMACY NUMBER (**_____**)**______**-**_______
PHARMACY MAJOR CROSS STREETS:__________**/**_________**CITY:**________________

DO YOU HAVE A MAIL ORDER PHARMACY? If yes which one:

____

ER CONTACT: ___________________________________RELATION: __________________

ER CONTACT PHONE #: (______) ______-________OTHER # :(______) ______-__________

INSURANCE CARRIER: ____

MEMBER ID #____

POLICY HOLDER: ________________________________DOB: ___/_______/__________

****ASSIGNMENT RESPONSIBILITY & RELEASE:**

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, <u>I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON COVERED SERVICES AND ATTORNEY OR COLLECTION AGENCY FEES IF IT BECOMES NECESSARY.</u> I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS CLAIM.

DO YOU HAVE A LIVING WILL: YES: _________________NO: _____________

DO YOU HAVE A MEDICAL POA: YES: _______________NO: _____________

IF YES WHO? ____

********PLEASE PROVIDE A COPY OF THIS FOR YOUR IN-OFFICE FILE**********

Effective January 1, 2023 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**. Any established patient who fails to show or cancels/reschedules an appointment with **no 24 hour notice** a second time will be charged a **$50.00 fee.** If a third **No Show** or cancellation/reschedule with no **24 hour notice** should occur the patient may be dismissed from Ace Health and Wellness. Any new patient who fails to show for their initial visit will not be rescheduled. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

PATIENTS SIGNATURE: __________________________________DATE: _____/_____/______