INDUSMEDICAL ASSOCIATES

DEMOGRAPHICS
FARZANA QURESHI MD, FACP

DATE / FECHA_____

PATIENT'S FULL NAME: _____ PHONE: _____
(NOMBRE COMPLETO) (NUMERO DE TELEFONO)

D.O.B: ____/___/_____ SEX / SEXO: M F SOCIAL SECURITY NUMBER: _____ - _____ - _____
(FECHA DE NACIMENTO) (NUMERO DE SEGURO SOCIAL)

ADDRESS: _____ CITY: _____
(DIRECCION) (CIUDAD)

STATE: _____ ZIP CODE: _____
(ESTADO) (ZONA POSTAL)

MAILING ADDRESS: _____ CITY: _____
(DIRECCION DE CORREO) (CIUDAD)

STATE: _____ ZIP CODE: _____
(ESTADO) (ZONA POSTAL)

NAME OF SPOUSE: _____ E-MAIL _____

(NOMBRE DE ESPOSO / ESPOSA)_____ CELL: _____

ETHNICITY: _____
(ORIGEN ETNICO)

PREFERRED LANGUAGE: _____
(LENGUAJE PREFERIDO)

RACE: _____
(RAZA)

EMERGENCY CONTACT / CONTACTO DE EMERGENCIA

NAME: _____ NAME: _____
(NOMBRE) (RELATIONSHIP TO PATIENT) (NOMBRE)

ADDRESS: _____ ADDRESS: _____
(DIRECCION) (DIRECCION)

PHONE # _____ PHONE # _____

NAME OF YOUR PHARMACY / NOMBRE DE SU FARMACIA : _____

CITY / CIUDAD: _____ PHONE / NUMERO DE TELEFONO: _____

760.202.0686
www.indusmedicalassociates.com
35400 Bob Hope Drive, Suite 209
Rancho Mirage, CA, 92270

INDUS MEDICAL ASSOCIATES

Farzana Qureshi MD, FACP
Infectious Diseases

Patient Financial Agreement

1. I understand that I am required to pay for all the charges on the date services are rendered, unless I am covered by a health plan in which my doctor is a participating physician, and I am being seen for a service I know to be covered by my policy.

2. I understand that Indus Medical Associates accepts personal check, cash or credit card. If the bank returns my check for insufficient funds, I will be charged a $25.00 service fee, which will be due and payable within three days along with the amount of the original check.

3. I understand that if I receive a statement in the mail, the amount is my responsibility and is due in 10 days.

4. If my account exceeds 90 days, I understand that I am in a collection status and a financial charge equal to 1% per month may be added to my account.

5. If unable to keep appointment, please let us know 24 hours in advance to avoid a $25.00 cancellation fee.

6. For any form to be filled out there is a charge of $20.00 per form.

Medical Insurance Policies

1. I understand that I am ultimately responsible for my account in full, even though I have medical insurance, should there be a problem with my insurance company not paying in a timely manner or for the amount I feel is correct, I agree to pay the doctor and settle my differences with my insurance company.

2. I will pay all deductibles or percentages due on the day of service, or in the case of surgery, a partial payment will be required prior to hospitalization.

3. I hereby authorize disclosure of medical information to my stated initial insurance company for the purpose of obtaining payment for services rendered.

MEDICARE PATIENTS

4. I have been given and have read MEDICARE'S ABN form on annual physical exams and routine tests and I am aware that the services rendered **may not be covered** by MEDICARE; therefore, I will be solely responsible for payment.

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE

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INDUSMEDICAL ASSOCIATES

Farzana Qureshi, MD, FACP
Patient Partnership Plan

Dear Patient, _____ Date of Birth____/____/_____

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "Partnership" between you and your doctor. As our "partner in health" we ask to help us in the following ways:

Schedule visits with Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow- up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know my condition progresses after I leave the office. Returning to my doctor on time gives him or her, the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointment as soon as possible.

Appointments that are not cancelled with 24 hours in advance will result in a $25.00 fee.

Call the Office When I Do Not Hear Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, ***at any time***, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Provider Signature

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Rancho Mirage, CA, 92270

INDUS MEDICAL ASSOCIATES

RECORDS RELEASE AUTHORITY

I, _____ hereby request that _____ **release** my health information as described below.

1. This authorization is limited to the following type of information:
   - ○ All medical information
   - ○ Immunization Record
   - ○ Medication List
   - ○ X-ray and Imaging reports
   - ○ Lab results
   - ○ All medical records relating to _____
   - ○ Other _____
2. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental services.
3. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

   INDUS MEDICAL ASSOCIATES
   Farzana Qureshi, MD
   35-400b Hope Dr. Ste 210, Rancho Mirage CA, 92270 Tel (760) 202-0686 Fax (760) 770-4563
4. The recipient may use the medical records and type of information authorized only for the following purposes:
   ○ Patient access ○ Continuation of care ○ Application for insurance ○ Other _____
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire on the following date, event, or condition in one year.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Director of Health Information Services.

NOTE: If our Physician feels the need to view records from your previous physician or specialist, we will fax this form with your signature of authorization to their office so they may release your records to us.

7. Please sign below:

_____ _____
Signature of Patient or legal Representative Date

_____ _____
Relationship to Patient Signature of Witness

Recipients of outpatient psychotherapy records are required to destroy these records within 60 days unless they are incorporated into the patient's medical records. It is the responsibility of the recipient to follow confidentiality policies and procedures for the maintenance and destruction of protected health information.

INDUS MEDICAL ASSOCIATES, INC.
35-400 BOB HOPE DR STE.210
RANCHO MIRAGE, CA 92270
PHONE: (760)202-0686
FAX: (760)770-4563

PATIENT: _____
SSN# _____
D.O.B: _____
PCP: _____