Geetha M. Reddy M.D.
American Board of Cardiovascular Diseases and Internal Medicine

Patient Name: _____
Last First MI

Address: _____
Street City State Zip Code

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Birth date: _____ **Age:** _____ **Social Security#** _____

Sex: [ ] Female [ ] Male **Marital Status: S M D W** Circle One

Employer: _____ **Work Phone: ( )** _____

Referring/Primary Dr. _____ **Dr. Phone ( )** _____

Name of Spouse or Parent: _____ SS# _____

Birth date: _____

PLEASE PRESENT INSURANCE CARD TO BE COPIED (CO-PAYS ARE COLLECTED BEFORE VIST)

Primary Insurance Name:_____ Secondary Insurance Name:_____

HAVE YOU FILED A CLAIM FOR:

Workman's Compensation? YES or NO Date of Injury: _____

Auto Accident? YES or NO Date of Accident: _____

INSURANCE / MEDICARE / MEDICAID/ AUTHORIZATION

I hereby authorize Dr. Reddy's office to release any information acquired to my insurance company and referring doctor. I also authorize benefits to be paid directly to Dr. Reddy for services rendered. I understand I will be responsible for any unpaid balance, including charges for which a referral was not obtained.

PATIENTS FINANCIAL POLICY PLEASE READ CAREFULLY

We are dedicated to providing the best care and service to you and regard your complete understanding of our financial policies as part of our service. Our office makes every attempt to keep up with the constant changes of your insurance company. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if your insurance company does not render payment in a timely manner, we will look to you for a payment. If later we receive a check from your insurer, we will refund any overpayment to you. Please be aware that some procedures might not be covered or may be denied by your insurance plan. Therefore, you will be fully responsible for payment should such occur.

****ALL HMO / EPO / POS PATIENTS MUST PRESENT A REFERRAL AT THE TIME OF APPOINTMENT****

A Gentle Reminder...

In order for us to continue to provide you with the quality care you deserve, there will be an appointment charge for each missed appointment. Thank you kindly for understanding our standard of care.

DATE: _____ SIGNATURE: _____