H. KIRAN KUMAR REDDY MD, PROFESSIONAL CORPORATION
American Board Certified in Internal Medicine and Cardiology

Clinical Cardiology
Cardiac Catheterization
Internal Medicine
Angioplasty

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization cretaes and maintains health records describing my health history, sumptoms, examination and test results, dianoses, treatment, and my plans for future care or treatment. I understand that this information serves as:

a basis for planning my care and treatment

a means of communication among the health professionals who contribute to my care

a source of information for applying my diagnoses and clinical information to my bill
a means by which a third party payer (eg. Insurance carier) can verify that services billed were actually provided

and a tool for routine healthcare operations such as assessing quality and outcomes

I have been provided with a *Noticy of Privacy Practices* that provides a more complete description of information uses and disclosures.

_____ _____ _____
Signature Relationship to Patient Date

_____
Please Print Patient's Name

_____ _____
Witness Date

Acknowledgement of Receipt of Notice of Privacy Practices was not signes as noted below:

- ☐ Patient Refuses to Sign
- ☐ Patient was Physically Unable to Sign

The following attempts were made to obtain signature.

Date	Time	Explanation/Reason	Initials

1114 W. 6th St. Suite 102 Hanford Ca. 93230 PHONE (559)587-9901 FAX (559) 582-9755

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION, AUTHORIZATION TO PAY PHYSICIAN

I authorize the release of any medical information necessary for the processing of medical insurance claims.

I hereby authorize my insurance company to pay H. Raj Reddy, M.D. the medical and surgical expense benefits allowable and including major medical benefits, as payment towards the total charges for professional services rendered. I understand that I am financially responsible for paying my account, including any balance after insurance payments.

_____ _____

Insured Signature / Authorized Person **Date**

_____

Patient

_____

Name (please print)

_____

Address

_____

City, State, Zip

AUTHORIZATION FOR MEDICARE PAYMENT

(MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made to H. Raj Reddy, M.D. on my behalf for any services rendered to me. I authorize all medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HFCA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorize releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

Insured Signature Date

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FINANCIAL POLICY

The following is the policy of H. KIRAN REDDY MD. Please read carefully and make sure you understand the following that applies to you before signing this agreement.

INSURANCE AND CONTRACTED INSURANCE PLANS (HMO/PPO): It is the patient's responsibility to supply us with the appropriate billing information. This includes current insurance identification, billing address and anything else required by your insurance carrier for payment of claim. You will be responsible for the full amount of our charges if incorrect or incomplete information is provided at the date of your service. You will be responsible for payment of any co-insurance, co-payment, deductibles or non-covered benefits. If we bill your insurance company and they do not pay the claim within 60 days, the balance on your account will become your sole responsibility. It is your responsibility to obtain referral or authorization if your insurance requires one.
Please remember that insurance is considered a method of reimbursement. Even with insurance coverage you are ultimately responsible for your bill. Although we do our best to help, problems with insurance payments, that may occasionally arise, are disputes between you and your insurance company.

MEDICARE: H. KIRAN REDDY MD is a participating provider of Medicare. We do accept, Assignment on Medicare claims. You are responsible for the deductibles, co-insurance, and non-covered benefits. If you have a secondary insurance we will bill the secondary upon receipt of the Medicare Explanation of benefits. If we bill your insurance company and they do not pay the claim within 60 days, the balance on your account will become your sole responsibility.

NON-INSURED: Payment is expected at the time of service. If you are unable to pay the full amount at that time, our billing department will work with you to establish a payment schedule. Once the payment has been established you are expected to make that payment on a monthly basis. If payment is not made the account will be considered delinquent.

It is the policy of this office to send delinquent accounts to a collection agency. Therefore, it is important that you contact the billing department if you are unable to make a payment on your account.

If at any time you need assistance or need to discuss the above policy, please feel free to call our office. Out goal is to provide you with optimal service and care.

I have read the above financial policy. By signing below I am acknowledging my understanding of my obligations and agree to abide by the financial policy.

_____ _____

Patient's Name (Printed) Patient's Signature Date

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