Vidhya Subramanian, MD PA
Endocrinology & Diabetes
16659 Southwest Fwy, Suite 205
Sugar Land, TX 77479
Tel: 832-532-7514; Fax: 832-532-7801

PATIENT CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Dr. Vidhya Subramanian, MD PA will create and maintain health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health information. It also explains how I may AMEND my medical records, obtain a RECORD OF DISCLOSURE or file a COMPLAINT regarding disclosure of my records. I understand that I have had the right to review the notice before signing this consent. I understand that the organization reserves the right to change their Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out the treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have been made in reliance on my prior consent.

THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Any and all records, whether written or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, health care operations as defined in the NOTICE OF PRIVACY PRACTICES without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health operations be restricted. I also understand that Dr. Vidhya Subramanian, MD PA and I must:
    a. Agree to any restriction in writing that I request on the use and disclosure of my protected health information; and
    b. Agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

_____ _____

Patient's Signature Date

_____ _____

Patient's Printed Name DOB (for Identification only)

Financial Policy **Vidhya Subramanian, MD PA**

Basic Policy: Payment for service is due in full, at the time our office renders service. Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance or a remaining balance that your insurance company states is your responsibility according to terms of your plan. Please contact them for clarification of benefits, as they do not always provided that information to our office.

- HMO Plans: All co-pays must be satisfied at every visit. you are responsible for getting referral information 72 hours-in-advance of your scheduled appointment with a specialist. If you do not get a referral, you will be responsible for the office visit in full.

- PPO Plans: All co-pays must be satisfied at every visit. you are responsible for coinsurance costs, non covered service, pre-existing coverage and deductible as stand in your plan. Please refer to your policy or customer service for plan clarification.

- Traditional Indemnity Plans: You are responsible for the stated % of total charges (prior to any adjustments made by the healthcare plan). A bill will be mailed to you in the event this deductible that was not satisfied. Please refer to your policy or customer service for plan clarification.

- Medicare/Medicare Insurance Type Plans: As a participating provider, we will file directly with your plan and secondary insurance, if one has been elected. You will be billed for deductible and coinsurance according to plan.

- Secondary Insurers: Having more than one insurance policy doesn't necessarily mean that your service are cover at 100%. You are responsible for any balance after your insurance companies have processed your claim. Please advise which plan is primary and which is secondary to assist with your claim processing.

Forms of Payment Accepted: Cash, Credit Card, such as Visa, and American Express. For outstanding balance, monthly statements are mailed to address provided to our office. Should your account be turned over for processing, you will be responsible for the account balance.

By signing below, I fully understand the financial policy by the office of Dr. Vidhya Subramanian and agree with the terms. I also understand and agree to terms of this financial policy may be amended by the practice at any time without prior notice to this patient.

_____ _____

Signature of Patient / Guardian (relationship) Date of Service