Subra K. Naidu, M.D., F.A.C.P., F.A.C.E.
Endocrine & Diabetes Consultants

Patient Sign-In Sheet

Date _____

Patient's Full Name_____ DOB_____ Age_____

Guardian/Parent Name (if applicable) _____

Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____ Email_____

Social Security#_____ Driver's License#_____

Occupation_____Employer_____Work Phone_____

Referring Physician_____Physician Phone_____

Marital Status (circle one): Single Married Widowed Divorced Separated

Spouse's Name_____Employer_____Work Phone_____

In case of an emergency contact: Name_____Phone_____

If someone other than the patient is responsible for payment, please provide their name, address and phone number:

_____

Insurance Co_____Policy Holder's Name_____Policy Holder's DOB_____

Medical Insurance: For copying purposes, please give your insurance I.D. card and driver's license to the receptionist.

Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of the practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours, and to make comments to the same.

Consent Form

I hereby authorize Subra K. Naidu, M.D. or his associates to provide any diagnostic tests and medical treatment as deemed proper in their judgment. I understand that I am responsible for any amount not covered by my insurance (for office visits, hospital doctor visits and all tests performed).

I understand that 48-hours notice is requested for cancellations, and that I will be responsible for a $25 Fee for office visits not canceled before 24 hours.

In connection with the medical services that I am receiving from the above-named physician and/or group, I hereby authorize the above-named physician and/or group to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party covering the medical service of the patient;
B. Other health care professionals and institutions involved in the delivery of healthcare to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:_____

This consent is valid from the date executed until revoked in writing by the patient.

**Signature:*_____ *Date:*_____

(Patient/Guardian)

**Witness:*_____ *Date:*_____

(E & D Consultants, PC)