

Patient Intake Forms

New Patients: We require you and/or authorized representative to review, complete and then sign the relevant forms.

Existing patients: Please update any relevant information that has changed since your last visit, or you feel appropriate to notify us of the changes. This includes but limited to change of insurance, address, contact information, health conditions, confidential and electronic communications preferences.

For Office Use:

Patient Information Form	Signed	
Health History	Signed	
Confidential and Electronics Communication request	Signed	
Financial Agreement and billing policy	Signed	
Receipt of Notice of Privacy Practices and HIPAA	Given	



Durga Madala, M.D. Inc.

Patient Name: _____

Gender: Male or Female or _____. DOB: _____

Email Address: _____. Alt Email: _____

Home Phone: _____. Alternate/Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Doctor: _____

Referred By: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____. Phone: _____

Relationship: _____. Email: _____

Responsible Party (if not self): _____ Phone: _____

Relationship: _____. Email: _____

Insurance Information. **Copies of Insurance Cards Will Be Required**

Primary Insurance: _____ ID# _____ Grp# _____

Secondary Insurance: _____ ID# _____ Grp# _____

Have you seen Dr. Madala before? _____ If yes, when and where? _____

I agree to review and sign the following documents, or similar ones as requested by the office of Durga Madala MD Inc. I am allowed to keep copies of the same:

- Privacy Practices and HIPAA Form
- Health History Form
- Financial Agreement and Billing Policy
- Receipt of Privacy Practices, Confidential Communications Request Form

I/we acknowledge and accept full responsibility for all charges incurred due to treatment by the office of Durga Madala MD Inc., including but not limited to co-payments, deductibles, and non-covered services.

Patient Signature: _____ Date: _____

Responsible party signature: _____ Date: _____



HEALTH HISTORY

CONFIDENTIAL

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS (check all symptoms that you currently have or have had in the past year)

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Ear discharge	
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	WOMEN ONLY
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Sweat	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Breast lump
	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Extreme menstrual pain
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Hot flashes
	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision - flashes	<input type="checkbox"/> Nipple discharge
		<input type="checkbox"/> Vision - halos	<input type="checkbox"/> Painful intercourse
MUSCLE/JOINT/BONE			<input type="checkbox"/> Vaginal discharge
Pain, weakness, numbness in:			<input type="checkbox"/> Other
<input type="checkbox"/> Arms <input type="checkbox"/> Hips	CARDIOVASCULAR	SKIN	Date of last menstrual period _____
<input type="checkbox"/> Back <input type="checkbox"/> Legs	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Bruise easily	Date of last Pap Smear _____
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hives	Have you had a mammogram? _____
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Itching	Are you pregnant? _____
	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Change in moles	Number of Children? _____
GENITO-URINARY	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Rash	
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Scars	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Sore that won't heal	
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Varicose veins		
<input type="checkbox"/> Painful urination			

CONDITIONS (CHECK CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST)

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease



MEDICATIONS – List medications you are currently taking	ALLERGIES – To medications or substances
Pharmacy: _____	Location: _____

FAMILY HISTORY						
Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications

Have you ever had a blood transfusion? (circle one) YES NO If yes, please give approximate dates _____

HEALTH HABITS - Check which substances you use and amount		OCCUPATIONAL CONCERNS - Check if your work exposes you to the following	
<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	Stress
<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	Hazardous Substances
<input type="checkbox"/>	Street Drugs	<input type="checkbox"/>	Heavy Lifting
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Other
<input type="checkbox"/>	Other	Your Occupation: _____	

SERIOUS ILLNESS/INJURIES/SURGERIES	DATE	OUTCOME

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date



Durga Madala MD Inc.

**RECEIPT OF NOTICE OF PRIVACY AND HIPAA
Confidential and Electronic Communications Request**

Patient Name: _____ DOB _____

Release of Information:

I hereby give permission for Dr. Madala and/or the office to release medical information concerning myself to the following individuals. This list may be modified in writing at any time.

Name of Individual

Relation to Patient

Acknowledgment of receipt of Notice of Privacy Practices and HIPAA:

I acknowledge that I have received a copy of the Notice of Privacy Practices and HIPAA, or I was provided the opportunity to take a copy with me. I also understand that I may request a copy from the office of Durga Madala MD Inc. at any time in the future.

Signed: _____

Date: _____

If not signed by the patient, please indicate relationship:

Parent of guardian of minor patient

Other

Signed: _____

Consent for communications via phone and electronic means:

I consent to receive communications from Durga Madala MD Inc., via the following, including electronic methods (please check all that apply):

- Contact me by phone: YES NO
- Leave messages on my answering machine or voice mail YES NO

- Email: _____ YES NO
- Text Messages to Phone Number: _____ YES NO

Types of Communications: I understand that these communications may include but are not limited to:

- Appointment reminders, Billing information, Statements
- Test results
- General health information related to my care

Security and Risks: I acknowledge that while efforts will be made to keep electronic communications secure, email and text messaging may not be completely secure methods of communication.

Right to Revoke Consent: I understand that I have the right to revoke this consent at any time by notifying the Doctor's office in writing.

Patient Consent: By signing below (or clicking 'I agree' electronically), I confirm that I have read and understood the above information and voluntarily consent to receive electronic communications as described.

Patient Signature: _____

Date: _____



Durga Madala MD Inc. Financial Agreement and Billing Policy

Name of Patient: _____

DOB: _____

Thank you for choosing Durga Madala, M.D., Inc., as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship.

Co-pays/Patient payments: Patients are required to present their insurance card(s) at each visit. Co-payments and any outstanding balances must be settled at the time of check-in, unless prior arrangements have been made with our billing coordinator. We accept payments via check, debit cards, and credit cards.

For us to credit the payments made to proper account, all checks, and other forms of payments must include the Name of the Patient, at the minimum and other details of services rendered. Please also keep the receipts or other forms of documentation of the payments that you made.

Insurance Billing Policy: Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. As a courtesy, we will bill your primary insurance company. To facilitate accurate billing, it is imperative that you provide us with complete insurance information, including primary and secondary insurance details, and promptly update us of any changes. Failure to provide complete information may result in you being responsible for the entire bill.

While we may estimate what your insurance company will cover, the final determination of your eligibility and benefits lies with your insurance company.

Participating Insurances: It is your responsibility to verify if our practice is contracted with your insurance plan prior to your visit, as participation may change. You will be responsible for payment regardless of any changes in our network status, in network or out of network.

Out of Network: Our office provides a comprehensive rate card or fee schedule for self-pay patients and out-of-network patients, detailing the costs associated with various medical services and procedures.

- If we are out of network with your insurance company, full payment may be required at the time of service. If you have already paid the full fee to our office, any reimbursement received directly from your insurance company will be retained by you.
- If we are out of network with your insurance company and you have not paid us at the time of service, you are responsible for promptly forwarding any reimbursement received directly from your insurance company for our services to us. You must also pay any difference between that amount and the fees charged.

In both cases, you agree to cover any charges not reimbursed by your insurance or paid on your behalf, which may include amounts exceeding the usual and customary allowance.

Referrals and Preauthorization: Certain insurance plans (e.g., HMO, POS) require referrals or preauthorization from your Primary Care Provider before seeing a specialist. You are responsible for obtaining these documents. Failure to do so may result in reduced or no payment from your insurance, leaving the balance as your responsibility.

Self-pay Accounts: Patients without insurance coverage, those preferring to pay directly, or those covered by non-participating plans are considered self-pay. Our office provides a comprehensive rate card or fee schedule for self-pay patients, outlining the costs associated with various medical services and procedures. This fee schedule is designed for patients who do not have insurance coverage or who prefer to pay out-of-pocket. Extended payment arrangements are available upon request; please contact our billing coordinator or office manager to discuss options.

General Responsibilities: Please inform our office promptly of any changes in your personal information (address, name, insurance details, etc.). If you have any questions regarding our fees, policies, or your responsibilities, feel free to ask.



Durga Madala MD Inc. Financial Agreement and Billing Policy

Other Charges:

Missed Appointments: We require a minimum of 24-hour notice for appointment cancellations. Failure to cancel a consult appointment may result in a \$50 fee. Additional cancellation policies apply to specific procedures.

Returned Checks: A \$25 fee will be charged for returned checks.

Medical Record Copies: Patients requesting copies of medical records will be charged a nominal fee to defray the costs for time and materials.

EDD/FMLA Forms: There is a \$25 fee for EDD/FMLA forms, with an additional \$10 fee for each extra form. Please allow 5-7 business days for processing. Urgent requests should be noted at the time of submission.

Minors: Parents or guardians are responsible for full payment and will receive billing statements. Unaccompanied minors may require a signed release to treat.

General: All patients over 18 receiving treatment are responsible for payment, regardless of any external arrangements.

Statements and Outstanding Balance Policy: Accounts with balances will receive a statement periodically, usually once a month. Insurance companies sometimes take 30-90 days to make payments. Please note that payments made by you or someone else on your behalf, whether partial or in full, may not immediately reflect in your balance. If you have made a payment and are unsure if it has been received or posted, please request an email confirmation by emailing to billing@madalamd.com.

For billing matters, while we make every effort to answer phone calls, we kindly ask that you send an email to billing@madalamd.com for all inquiries. This allows our staff adequate time to thoroughly research and respond to your questions.

We may contact you by phone, text, email, or mail as permitted by your consent to communicate with our office. This allows us to send statements or discuss potential payment arrangements. Prompt attention to any outstanding balances is crucial. Parties responsible for delinquent accounts will be charged a late fee of 10% and interest of 7% per year. Past due accounts may face collection efforts resulting in additional costs. We reserve the right to modify this policy as we see fit.

Our financial policy is crafted to uphold the highest standards of patient care. Please reach out to us with any questions or for further clarification on these policies.

By signing below, I certify that I have reviewed the financial policies outlined above. I confirm my understanding of my financial responsibilities and accept full accountability for all charges, regardless of any payments made by applicable insurance coverage.

Patient Name: _____ Signature: _____ Date: _____

Responsible party's Name and Signature, (if different than patient):

Name: _____ Signature: _____ Date: _____