R.B. Kolachalam, M.D., P.C.
Section Chief Dept of General Surgery, Providence Hospital
General & Laparoscopic Surgery
Diplomat of the American Board of Surgery
Clinical Associate Professor in the Department of Surgery at Michigan State University

Patient Information

Please print

Patients Name:_____ **D.O.B**____/____/_____

Current Address :_____ Apt/Uite #_____

City_____State_____Zip_____

Phone_____Cell_____Work _____

If you move or plan to move within the next 12 months , please provide address:
Current Address :_____ Apt/Uite #_____

City_____State_____Zip_____

Email Adress _____

social security #_____

Material Status: please circle Married Single Widowed Divorced Domestic Partner

Emergency Contact
Name_____ Relationship_____

Phone Number_____

Pharmacy Information
Name_____

Phone_____ Fax_____

Address (or cross roads) :_____ City _____

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Do you have any of the fallowing	YES	NO
Diabetes		
High Blood Pressure		
Heart Diseases Heart attack, Heart Failure		
Irregular heartbeat		
Pacemaker		
Stroke		
Blood clots		
Emphysema / COPD		
Kidney failure		
Weight loss		
Asthma		
Heart Burn		
Do you have any of the fallowing	YES	NO
Cancer		
Hepatitis C		
HIV / AIDS		
High cholesterol		
Sleep Apnea		
Colonoscopy		
Mammogram		

Urinary Difficulty:

Complications during past surgeries:

Family history: Please circle which applies

Father	Alive	Deceased	Cancer	Stroke	Diabetes	High Blood Pressure
Mother	Alive	Deceased	Cancer	Stroke	Diabetes	High Blood Pressure
Sibling	Alive	Deceased	Cancer	Stroke	Diabetes	High Blood Pressure

Please list all Current Medication and Dosage
Please Print

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Medication:_____Dose _____

Do You have Any allergies? ____**yes** ____**No**
if yes please list allergies

_____

_____

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Tobacco Use: ___Yes ___No

If yes, how many cigarettes per day ?_____

Did you have a drink containing alcohol in the past year?_____ Yes ____ No

if yes, how often do you have a drink containing alcohol?

Monthly or More _____

Have You ever Used drugs ? _____Yes_____No

if Yes Please list

_____

Have you been hospitalized within the past 5 years? ___ Yes____ No_____

_____

_____

Please list or check the surgical history along with the month and year of surgery:

Surgery	*Month*	*Year*
Appendectomy		
Cholecystectomy		
Gastric Bypass		
Hysterectomy		
Inguinal hernia surgery		
Thyroid Surgery		
Breast Biopsy		
Knee replacement (R)		
Knee replacement (L)		
Hip Replacement (R)		
Hip Replacement (L)		
Colon Resection		
Coronary Stents		

Additional surgeries: _____

_____

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Height_____**and weight**_____

Do You have an Advance directive? ____**Yes**____**No**

If you checked yes, please **print** name _____and relation_____

Please describe current level? 0-10

0-------1-------2-------3-------5--------6 -------7--------8--------9--------10

No pain Moderate Pain Worst Pain

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Providence Park Medical Center
26850 Providence Parkway
Suite 460
Novi, MI 48374

Phone: (248) 662-4272
Fax: (248) 662-3020
Kolachalamsurgery.com
rbksurgery@yahoo.com

HIPPA Notice and Acknowledgement

I acknowledge that I have received the preceding Notice of Privacy Practice

Patient Signature _____ Date _____

Personal Representative to patient signature _____ Date _____

Representative Name _____ Relationship to patient _____

If there is a person you would like our office to be able to speak regarding any medical information, such as lab results, radiology, office appointments, prescriptions, surgeries, etc please list below. this will out office permissions to discuss any of your personal medical information with.

. Thank you

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

DR. R.B. KOLACHALAM M.D.

TELE: (248) 662-4272 FAX: (248) 662-3020

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize R.B. Kolachalam M.D. to release healthcare information of the patient named above to:

Name: Any or all Healthcare Providers

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☒ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

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Primary care Physician

Dr_____
Last Name First Name

City_____ Phone_____ Fax_____

Refereeing Doctor

Dr_____
Last Name First Name

City_____ Phone_____ Fax_____

Cardiologist

Dr_____
Last Name First Name

City_____ Phone_____ Fax_____

OB/GYN

Dr_____
Last Name First Name

City_____ Phone_____ Fax_____

Oncologist

Dr_____
Last Name First Name

City_____ Phone_____ Fax_____

R.B. Kolachalam, M.D., P.C.

Payment Policy

Thank you for choosing Dr. Kolachalam as your general surgeon. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions your may have, an sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS SAND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company,. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Your health insurance policy is a contract between you and your insurance company. As a service to you, R.B. Kolachalam MD PC will send a claim to your health insurance company. By working together, we can minimize misunderstandings, payment delays and billing costs. However you are responsible for any charges not covered by your benefit plan.

3. NON-COVERED SERVICES. Please be aware that some-and perhaps all-of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof on insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. LAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid , we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party _____ Date _____

PLEASE KEEP THIS NOTICE FOR PRIVACY PRACTICES FOR R.B KOLACHALAM, MD PC

This describes How medical information about you may be used and disclosed and how you can get access to this information Please review carefully.

This notice of privacy practices is being provided to you is a requirement of the health care insurance portability and accountability act(HIPPA). This notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other professed that are permitted or required by law. It also describes a right to access and control your protected health information in some cases. You're protected health information means any of your written or oral health information that is created or receive by your healthcare provider in that relates to your past, present, or future physical or mental health condition.

I • Uses and disclosure of protected health information.(PHI)

The practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your PHI may be used for disclose only for these purposes unless practice and/or provider has obtained your authorization for the use or disclosure as otherwise provided by the HIPPA privacy regulations or state law. Disclosure of your protected PHII for the purpose described in this notice may be made in writing, orally, or by facsimile.

A. Treatment: We will use and disclosure PHI to provide, coordinate a manager healthcare of any related services this includes the coordination or management of the healthcare of any related services this includes coordination of management of your health care with a third-party for treatment purposes. For example, we may disclose your PHI to pharmacy to fill a prescription, to laboratory to order for a blood test, or to home health agency that is providing care in your home, we may disclose your PHI treatment provider for purpose of treatment activities we will use and disclosure of PHI to provide, coordinate a manager healthcare of any related services this includes the coordination or management of the healthcare of any related services this includes coordination of management of your health care with a third-party for treatment purposes. For example, we may disclose your pH try to pharmacy to fill a prescription, to laboratory to order blood test, or to home health agency that is providing care in your home, we may disclose your PHI to an outside treatment provider for purpose of treatment activities of The other provider.

B. Payment : your PHI will be used, as needed to 15 payment of service to be provided. This may include certain communications your help ensure to get approval for the treatment that we recommend. For example, if in the hospital admissions recommend it, we may need to disclose information to help ensure to obtain prior approval – authorization for hospitalization. And we also discussed P try to insurance company to determine whether you are eligible for benefits or whether a particular service is covered under health care plan. In order to get payment for your service, we may also need to disclose your PA try to insurance company to demonstrate medical necessity; As required by your insurance company, for your rosacea and review. We may also discussed patient information to another provider involved in your care for other providers payment activities.

C. Operation: We may use or disclose your PHI as necessary for our own healthcare operations in order to facilitate the function of the practice into provide Claudio care to our patients. Healthcare operations include such as activities:

•Quality assessment and improvement activities
• employee review activities
• training programs include those in which a student, training, or practitioner and healthcare learn under supervision.
• Accreditation , certification, Leslie or credentialing activities
• review and ordering, including compliance review, medical review, legal service, and maintaining compliance programs
• Business management and general administrative activitie

In certain situations, we may also disclose patient for information to another provider or health plan for their health plan for their health care operations.

D. Other uses and disclosures. As part of treatment, payment, and healthcare operations we may also use or disclose your PHI for the following purposes : see remind patient of an appointment. To inform patient of potential treatment alternatives options.