Sunita Swamy, MD, PA 1600 W 38TH ST Ste 406 Austin, TX 78731 512.394.7377 **PATIENT INFORMATION**	❑ **Established Patient** **THIS PACKET IS ONLY FOR ESTABLISHED PATIENTS.**

Patient's FIRST Name:	MIDDLE:	LAST:	Social Security #:

Birth date:	Sex:	Marital status (circle one)	Employment Status (circle one)	Employer Name:
/ /	❑ M ❑ F	Single / Mar / Div / Sep / Wid	Employed / Retired / Student / Not-Employed	

Home Address:	City	State:	Zip Code:

Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other	Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline	Language: ❑English ❑Spanish ❑Other:_____

Mobile#: ❑ Cell ❑ Work ❑Home	Phone#: ❑ Cell ❑ Work ❑Home	Email Address:
( )	( )	Appointment reminder by email? ❑ Yes ❑ No

Referring Physician Name:	How did you hear about our office?
Emergency Contact (name/phone/relationship to patient):	Pharmacy (name/address/phone):
My office does not handle, accept, or file worker's compensation claims. _____ Initial	I have read the Notice of Privacy Practices, explaining how my medical information may be used & disclosed. If requested, I am entitled to receive a copy of the Notice of Privacy Practices. _____ Initial

POLICY HOLDER/RESPONSIBLE PARTY: Minors under 17y/o and Dependent Patients over 18y/o

Policy Holder/Person Financially Responsible [Guarantor] ❑Self Only → Skip to insurance section ❑ Other → Complete this section	Policy Holder/Guarantor's Full Name (as it appears on insurance card):	Phone: Patient's Relationship to Policy Holder/Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:

Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑90/10 ❑ 80/20 ❑ 70/30 ❑ Other: ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (complete guarantor sect.) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

Initial: _____

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge.

I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I authorize my insurance benefits be paid directly to Sunita Swamy MD PA, as indicated on the claim, and I affirm that the insurance information provided above is up-to-date & valid.

_____
Initial

I understand that I am financially responsible for all fees and balances, including but not limited to those listed below, regardless of insurance coverage:

- Medical Records Fee:
  Per the Texas Medical Board rules including Section 165.2, the fee for Medical Records starts at $25 and increases depending on the total number of pages.

- Paperwork Processing Fees:
  There may be a fee for paperwork not exceeding $50, depending on the forms, information needed, and the time required to fill them out.

_____
Initial

Guarantor/Guardian signature: _____ Date _____

Initial: _____