NuWave Medical Center
Gurprit Sekhon, M.D.

Patient Information:

Dr.___Mr.___Mrs.___Ms.___Jr.___Sr.___ Date of Birth:_____/_____/_____Social Security Number:_____

Last Name:_____First Name:_____Middle Initial:_____

Local Address:_____City:_____State:____Zip:_____

Local Phone #'s Work:_____Home:_____Cell:_____

Out of State Address:_____City:_____State:___Zip:_____

Country:_____ Out of State Phone #:_____

Marital Status: Married:_____Single_____Divorced:_____Widowed:_____ Male_____ Female_____

Employment Status: Employed_____F/T Student_____P/T Student_____Retired_____Self E mployed_____Unemployed_____

Employer Name/Self Employed Business Name:_____

Emergency Contact Name:_____Phone:_____Relationship to Patient:_____

Responsible Party Information:

Last Name:_____First:_____Middle Initial_____

Social Security Number:_____Date of Birth:_____/_____/_____ Male_____ Female_____

Primary Insurance Information:

Name of Insured:_____Pt. relationship to Insured:_____

Insured Employer Name:_____

Insurance Company:_____Phone # located on card:_____

Subscriber ID/Policy #:_____ Group ID:_____

Co-pay Amount:_____Insured Date of Birth:_____/_____/_____ Insured's SS#:_____

Secondary Insurance Information:

Name of Insured:_____Pt. relationship to Insured:_____

Insured Employer Name:_____

Insurance Company:_____Phone # located on card:_____

Subscriber ID/Policy #:_____ Group ID:_____

Co-pay Amount:_____Insured Date of Birth:_____/_____/_____ Insured's SS#:_____

Gurprit Sekhon, M. D.
10800 PCB Parkway, Ste. 200
PCB, FL 32407

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, a patient of this practice, may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy:

NuWave Medical Center is dedicated to maintaining the privacy of its' patients protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend our Notice. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI:

Our practice may use and disclose PHI for the purpose of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes:

***Treatment *Payment *Health Care Operations *Release or Sharing of Information *Research Purposes**
***The Rights of Minors and Personal Representatives *Release of Information to Business Associates *Marketing Purposes**
***Release of Information Required by Law**

Your Health Information Rights

***Requesting Restrictions on PHI *Inspection and Copies of PHI *Amendment of PHI *Accounting or Disclosures**
***Right to a Paper Copy of this Notice *Right to File a Complaint *Right to Provide Authorization of Other Uses/Disclosures**

If you have questions regarding this notice or our health information privacy policies, please contact Dr. Gurprit Sekhon at 850-249-6363.

AUTHORIZATION FORM TO SHARE "PROTECTED HEALTH INFORMATION"

Purpose:

To permit Dr. Gurprit Sekhon to respond to patient inquiries regarding Protected Health Information

Section 1

Patient who's Protected Health Information may or may not be disclosed:

Name:_____ Date of Birth:_____

Section 2

Identify the person(s) with whom your information may be shared and their relationship to you:

My information may be shared with: (Please Print)

Name:_____Relationship:_____

Name:_____Relationship:_____

Section 3 How would you like your information to be left if we are unable to speak with you (check all that apply)?

( )Home Telephone:_____
- ( )Ok to leave message with detailed information
- ( )Leave message with call-back number only

( )Written Communication:
- ( )Ok to mail to my home address
- ( )Ok to mail to my work address

( )Work Telephone
- ( )Ok to leave message with detailed information
- ( )Leave message with call-back number only

Section 4

This Authorization will expire on:_____.

Signature of Patient and/or Legal Representative Date

DISCLOSURES & CONSENTS

(Please read the following, initial each one, sign and date at the bottom)

CONSENT FOR TREATMENT, PAYMENT & OPERATIONS:

Dr. Gurprit Sekhon is committed to protecting your health information related to your medical treatment, payment for your treatment, and/or health care operations related to your treatment. Our "Privacy Notice" is posted in the waiting room for your review.

___Initial-*I hereby consent to evaluation, testing and treatment as directed by my NuWave Medical Center healthcare provider or his/her designee. I further consent to allow NuWave Medical Center access to my current and previous prescription history.*

___Initial-*I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my Protected Health Information may be shared with the people listed and that they may not be required to comply with federal health information privacy laws and may use and further disclose any of my Protected Health Information they receive. I am also signing below that I have received a copy of the Privacy Notice.*

CONSENT FOR TREATMENTOF A MINOR CHILD (PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE)

___Initial-*As the parent or legal guardian of the minor patient_____(pt.'s name) I hereby give consent to evaluation, testing and treatment as directed by my NuWave Medical Center healthcare provider or his/her designee.*

INSURANCE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

___Initial -*I, the undersigned, certify that I (or my dependent) have insurance coverage with the carrier(s) stated and assign directly to Dr. Gurprit Sekhon all insurance benefits, if any, otherwise payable to me for services rendered. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible for the deductible, coinsurance and/or non-covered services. I hereby authorize Dr. Gurprit Sekhon to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

___Initial -*I hereby assign to NuWave Medical Center any insurance or other third-party benefits available for health care services provided to me. I understand that NuWave Medical Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NuWave Medical Center, I agree to forward to NuWave Medical Center all health care insurance and other third party payments that I receive for services rendered to me immediately upon receipt.*

MEDICARE/CHAMPUS/TRICARE INSURANCE BENEFITS:

****I certify that the information given by me in apply for payment under these programs is correct. I authorize the release of any of my medical records that these programs may request. I hereby direct that payment of my benefits be made directly to Nu Wave Medical Center, Gurprit Sekhon, M. D. on my behalf.*____Initial**

INJECTIONS/LAB/X-RAY/DIAGNOSTIC SERVICES:

___Initial-*I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.*

PAYMENT:

___Initial-*Claims not paid with a timely manner (90 days) by my insurance company, become fully my responsibility.*

___Initial-*Full payment for all co-pays, deductible and non-covered services are expected at the time of the appointment. Cash patients are responsible for the entire charge of their visit at the time of service.*

___Initial -*Past due balances. Prescriptions will not be administered to any patient who has a past due balance.*

___Initial-*There will be a $30 charge for any returned checks. If there is a history of 2 returned checks, all visits will require cash or credit card payment.*

APPOINTMENTS/MISSED VISITS:

___Initial -*It is the patient's responsibility to know the date and time of his/her appointment. We do not make appointment reminder calls. There will be a $25.00 charge for all missed visits unless there is a 24-hour notice for appointment cancellations.*

REFILLS:

___Initial *All prescription refills require an office visit. We do not call in or fax in refills. All patients must be seen. Please keep this in mind while visiting our provider. Sometimes your pharmacy will give you enough "courtesy" meds until your appointment time, please check with your pharmacy if your appointment is within 1-2 days of your prescription running out.*

Patient Signature:_____Date:_____

If someone else is signing this authorization form on behalf of the patient, please provide the following information:

Representative Signature:_____Date:_____

Relationship to the Patient:_____

Right to Revoke:

I understand that I may cancel my authorization at any time by giving written notice to the office. I further understand that cancellation of my authorization will not affect any action taken by Dr. Gurprit Sekhon prior to receiving my written notice of cancellation.

Signature of Patient/Legal Guardian:_____ _____ Date:_____/_____/_____

We fax in our prescriptions – please provide the name and location of your pharmacy below:

Pharmacy Name:_____Location:_____

How did you hear about our office?_____Who can we thank?_____

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Name:_____ **DOB:**_____

Address:_____

Phone Number:_____

Information to be Released:

___Office Notes
___X-Ray Report
___Laboratory Reports
From:_____To:_____

___Entire Record
___Hospital Records
___Other (specify)_____
_____

Please release the above information to:

Gurprit Sekhon, M. D./Nu Wave Medical Center
10800 Panama City Beach Parkway-Ste. 200
Panama City Beach, FL 32407
(850) 250-1649 – Telephone
(850)249-6680 – Fax

Purpose of Disclosure:
___Further Medical Treatment ___Changing Physician
___Other (Specify)_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relationship to Patient if signed by other than Patient **Witness**