Krishna V. R. Sunkureddi, M.D., P.A.
1406 Stonehollow Drive, Kingwood, Texas 77339
Office: 281-358-0502 Fax: 281-358-0085

EXISTING PATIENT INFORMATION

Name: _____DOB: _____Marital Status: _____

Street Address: _____ APT#_____

City: _____ State: _____ Zip: _____ Phone #:_____ (cell ___ home___)

Employer: _____ Work #: _____

Address: _____ Occupation: _____

If Minor, Legal Guardian:

Mothers Name: _____ Phone #: _____

Address: _____

Fathers Name: _____ Phone #:_____

Address: _____

INSURANCE INFORMATION

Insurance Co. Name: _____ID #:_____Group #:_____

Address: _____ Phone # to verify benefits: _____

Policy Holder's Name: _____Relationship: _____ Date of Birth: _____

Policy Holder's Employer: _____

Secondary Insurance (if applicable)

Insurance Co. Name: _____ID #:_____Group #:_____
Address: _____ Phone # to verify benefits: _____
Policy Holder's Name: _____Relationship: _____ Date of Birth: _____
Policy Holder's Employer: _____

I hereby authorize payment directly to Krishna Sunkureddi M.D., P.A., of any surgical and/or medical benefits, if any, and otherwise payable to me. I also authorize Krishna Sunkureddi M.D., P.A., to file all necessary papers for insurance and to release any and all copies of medical records requested by complete payment of any and all claims.

Signed: _____ Date: _____

Krishna V. R. Sunkureddi, M.D., P.A.

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Office Policies

1. Any patient who is abusive to my staff will be discharged from my practice.

2. Please let us know **24 hours** before your appointment time if your insurance has changed.

3. Our office tries to gives a **24 hours "Courtesy Call"** to patients; however it is **YOUR** responsibility to remember your appointment and arrive at least 30 minutes early.

4. We have a **"No Show Policy**". This means that if you don't call 24 hours before your appointment you will be charged $50.00 due at the time of your next appointment. **NO EXCEPTIONS!!** Three "No Shows" within an 18 month period will result in a patient's discharge.

5. Patients may be required to do a Urine Drug Screen (UDS), refusal to submit a sample may result in the patient's discharge from the practice.

6. Patients are expected to arrive 30 minutes early prior to appointment in order to complete paperwork, vitals, etc. Failure to do so can result in appointment being rescheduled.

7. It is the patient's responsibility to schedule and keep their follow-up appointments. (If you do not schedule your follow-up before you are due, we will not be able to call in any medication until your appointment.)

8. Forms to be filled out by Dr. Sunkureddi or other clinician, should be given to the front desk prior to appointment, **a $25.00 charge will apply at the time of appointment.**

9. Non-emergency phone calls will be returned within 24 hours.

10. Any prescription requested from this office requires a 24 hour notice. Patients who come to the office demanding same day service will be denied!!

11. LOST C-2 PRESCRIPTIONS ARE ONLY REPLACED WITH A POLICE REPORT. Expired C-2's will not be replaced.

By signing this office policy this lets us know that you have read, understood and agree to the above office policies**. Failure to comply with these policies could result in termination.**

Signature: _____ Date: _____

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Patient Financial Policy for the Practice of Krishna Sunkureddi, M.D., P.A.

Patient's Name: _____Date of Birth: _____

Patient agrees to pay for all portions of service due in full at the time services are provided by our office. Any outstanding balances, co-pays, co-insurance or deductibles are due prior to seeing the doctor.

You are required to present a valid insurance card at the time of appointment in order for services to be billed to your insurance.

We will make every effort to verify your coverage and benefits prior to your appointment but your agreement with your insurance company is a **PRIVATE AGREEMENT** so if at any time you disagree with the benefits we receive from your carrier it is your responsibility to follow-up with them. Regardless of any benefits quote, if you're insurance carrier has not paid within 60 days you are responsible for the full amount owed.

We will bill Medicare and Medicaid services for you. Please provide proof of coverage with Medicare, Medicare Advantage or Medicaid at the time of appointment.

If the patient is a minor, then the parent or guardian who accompanies the minor patient is responsible for payment of services. They may not sign another parent or guardian's name to the financial responsibility agreement. If there is another parent that should be responsible that parent/guardian should contact the office prior to appointment to make payment arrangements.

This office accepts cash, checks, and credit and debit cards as forms of payment.

Returned checks will be assessed a $30.00 NSF charge and checks will no longer be accepted from that patient. Patients that do not cancel appointments 24 hours in advance will be assessed a $50.00 charge. This charge is not billable to insurance.

If a patient requests payment arrangements and fails to keep up with terms they will be responsible for the full amount due or will be discharged from the practice. All outstanding balances must be paid with 3-6 months.

The patient is ultimately responsible for all fees for services rendered. I have read, understood and agreed to the above policy for this office.

Signature: _____ Date: _____