6301 Mountain Vista St STE 204 Henderson, NV 89014
Phone: 702-848-7744 Fax: 702-899-7086

PATIENT INFORMATION

LAST NAME: FIRST NAME: MIDDLE INITIAL:

DATE OF BIRTH: SOCIAL SECURITY #:

☐MALE ☐FEMALE SINGLE MARRIED DIVORCED SEPARATED WIDOWED

ADDRESS:

CITY: STATE: ZIP CODE:

HOME PH: CELL PH: EMAIL:

PREFERRED METHOD OF CONTACT: ☐TEXT ☐EMAIL

☐PHONE MAY LEAVE VOICE MAIL ☐YES ☐NO

EMERGENCY CONTACT: RELATIONSHIP: PH:

PHARMACY NAME AND ADDRESS:

PHARMACY PHONE NUMBER:

PRIMARY INSURANCE:

INSURED NAME: PH:

DATE OF BIRTH: SOCIAL SECURITY #:

POLICY #: GROUP #:

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize the release of information necessary to file a claim with my insurance company and I assign benefits to SIRIKANYA SASTRI MD OF VIROPANA HEALING SURGICAL CLINIC. We will gladly file your insurance claim, however, payment for copays and deductibles is required at the time services are rendered. We cannot guarantee the amount to SIRIKANYA SASTRI MD OF VIROPANA HEALING SURGICAL CLINIC. We have an agreement with you, not your insurance company for payment. If your insurance company denies a claim, you will become responsible for all amounts not covered payable to SIRIKANYA SASTRI MD OF VIROPANA HEALING SURGICAL CLINIC. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions, attorney & court filing fees, or interest rates assigned by the collection agency. I authorize the release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize the fax transmission of medical records if necessary.

SIGNATURE: DATE:

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of VIROPANA HEALING SURGICAL CLINIC assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay VIROPANA HEALING SURGICAL CLINIC for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If VIROPANA HEALING SURGICAL CLINIC is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, VIROPANA HEALING SURGICAL CLINIC is not involved. In order for VIROPANA HEALING SURGICAL CLINIC to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that VIROPANA HEALING SURGICAL CLINIC will need to verify my health insurance coverage. In the event that VIROPANA HEALING SURGICAL CLINIC is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable to me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

I**nsurance Authorization and Release:** I request the payment of authorized benefits, including Medicare, and any other government-sponsored program, private insurance, and any other health plans to be made to VIROPANA HEALING SURGICAL CLINIC for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize VIROPANA HEALING SURGICAL CLINIC to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of VIROPANA HEALING SURGICAL CLINIC charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize VIROPANA HEALING SURGICAL CLINIC to act as my agent to help me obtain any required pre-certification as well as act as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give VIROPANA HEALING SURGICAL CLINIC any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize VIROPANA HEALING SURGICAL CLINIC to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize VIROPANA HEALING SURGICAL CLINIC to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of VIROPANA HEALING SURGICAL CLINIC. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting VIROPANA HEALING SURGICAL CLINIC at 702-848-7744.

Personal Valuables: VIROPANA HEALING SURGICAL CLINIC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. The Medical Dock, A medical corporation, and the patient or the patient's representative, hereby enter into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, and is the patient, the patient's representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

SIGNATURE: _____ DATE: _____

VIROPANA
Healing Surgical Clinic

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

VIROPANA HEALING SURGICAL CLINIC "Practice" and Patient herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use a telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims, and damages to persons or property, losses, and liabilities, including reasonable attorney's fees, arising out of or caused by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses, and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, and may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engage in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of the same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage, and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as a compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes the consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT OF AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice's Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

VIROPANA
Healing Surgical Clinic

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- As part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a voicemail at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with another person/people? ☐ YES ☐ NO

If YES, please write their name, your relationship, and their phone number below:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____
NAME: _____ RELATIONSHIP: _____ PHONE #: _____
NAME: _____ RELATIONSHIP: _____ PHONE #: _____

SIGNATURE: _____ DATE: _____

VIROPANA
Healing Surgical Clinic

NOTICE OF NO AUDIO OR VIDEO RECORDING DURING MEDICAL VISITS

At Viropana Healing Surgical Clinic, we prioritize the privacy, security and confidentiality of our patients. In order to maintain a safe and comfortable environment for all patients and staff members, we strictly prohibit the recording of audio or video during medical visits without prior written consent.

The following policies are in effect:

1. **No Recording Without Consent:** Patients are not allowed to record any aspect of their medical visit, including audio or video without obtaining written consent from both the treating healthcare provider and the individuals involved. This includes but is not limited to consultation, examinations and procedures.

2. **Privacy and Consent Form:** If a patient wishes to record any portion of their medical visit, they must request and complete Privacy and Consent Form. This form outlines the intended use of the recording and is subjected to approval by the healthcare provider and the practice administration.

3. **Respect for Others:** Patients who record without consent not only breach our policy but also infringe upon the privacy and rights of healthcare providers, fellow patients, and staff members. We expect all individuals to treat each other with respect and dignity.

4. **Legal Consequences:** Violation of this policy may result in the termination of medical services at Viropana Healing Surgical Clinic and could potentially lead to legal action.

We understand that patients may have various reasons for wanting to record their visits, such as to remember instructions or share information with family members. However, our primary concern remains the protection of patient privacy and the maintenance of a safe and confidential healthcare environment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF RECORD POLICY

I acknowledge the receipt of this policy and I confirm that I have read and understood the policy regarding the prohibition of audio or video recording during medical visits.

PATIENT NAME: _____ DATE OF BIRTH _____

SIGNATURE: _____ DATE: _____