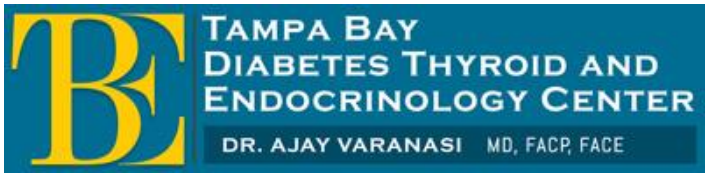


MEDICAL RECORDS RELEASE

5775 5th Avenue N. St. Petersburg, FL 33710
Ph: (727)345-5222 * Fx: (727)345-4066

Name:_____

DOB:_____

The following information may be shared with other providers:

(check all that apply)

Office Notes:___

Lab Results:____

Imaging:_____

Other:_____

Please list below all other specialists with whom we may share records

Physician	Specialty	Address/Phone

Signature_____

Date:_____

TAMPA BAY
DIABETES THYROID AND
ENDOCRINOLOGY CENTER
DR. AJAY VARANASI MD, FACP, FACE

Patient Information & Financial Responsibilities

We appreciate that you have trusted us with your healthcare. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements, to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, prior authorizations, limits on outpatient charges, and specific physicians and/or networks to use. You should be knowledgeable of any deductibles, copayments, and/or co-insurance. This applies to all payoffs regardless of whether our physician participates.

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Please make checks payable to:

In an effort to provide excellent care to our patients, we are requesting the courtesy of a phone call if you are unable to make your appointment. Please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. We thank you for your consideration to other patients who may need your appointment slot.

I understand that if I do not give a 24 hour courtesy call to cancel or reschedule my appointment, I may be charged a fee of $75 – INITIAL HERE_____

Should you have any question with regard to our policies we encourage you to ask. It is our goal, not only to provide you with the best quality of medical care, but to help you by answering any insurance questions you may have.

I have read the above and agree:

Signature_____Date_____

TAMPA BAY DIABETES THYROID AND ENDOCRINOLOGY CENTER
DR. AJAY VARANASI MD, FACP, FACE

Patient Information
Disclosures & Consent

Patient Name:_____ DOB:_____

Assignment Of Benefits:
I hereby authorize direct payment of my insurance benefits to Dr. Ajay Varanasi, MD for services rendered to me or my dependents by the physician or under his supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit under my policy. I understand and agree that I will be responsible for any copay or balance that Dr Ajay Varanasi, MD is unable to collect from my insurance carrier for whatever reason.

Medicare/Medicaid/Tricare/Champus Insurance Benefits:
I certify that the information provided by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Dr Ajay Varanasi, MD on my behalf.

Authorization To Release Non-Public Personal Information:
I certify that I have received and read a copy of the Patient Privacy Information Policy. I hereby authorize Dr. Ajay Varanasi, MD to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to Mail, Call, or Email
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize Dr Ajay Varanasi, MD to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and lab results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Ajay Varanasi to that effect in writing.

I AUTHORIZE THIS FACILITY TO REALEASE INFORMATION TO (PLEASE CHECK ALL THAT APPLY)
_____Spouse (name)_____
_____Children (name/phone)_____
_____Others
(name/phone)_____
_____No One

Lab/Xray/Diagnostic Services
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent For Treatment
I hereby consent for evaluation, testing, and treatment as directed by Dr Ajay Varanasi, MD or his designee.

Signature:_____ Date:_____

Patient Demographics

Patient Information

Name:_____ Address:_____

Age:_____ DOB:_____ Gender: M / F City:_____ State:_____ ZIP code_____

Social security:_____ How did you hear about us?_____

Home Phone:_____ Cell Phone: _____

Marital Status: Married – Divorced – Race: Asian – Black – White – Other:_____

Separated – Single – Widowed – Other Ethnicity: Hispanic – Not Hispanic – Unknown

Employee Status: Employed – Retired – Not employed / Full time – Part time

Student Status: Student – Not a student / Full time – Part time

Email address:_____

Responsible Party Check if same as patient [ ]

Name:_____ Address:_____

Age:_____ DOB:_____ Gender: M/F City:_____ State:_____ ZIP code_____

What is the patients relationship to responsible party?_____

Phone Number:_____

Emergency Contact Check if same as responsible party [ ]

Name:_____ Address:_____

Age:_____ DOB:_____ Gender: M/F City:_____ State:_____ ZIP code_____

What is the patients relationship to emergency contact ?_____

Phone Number:_____

Insurance Information Check if Self Pay [ ]

Check if same as responsible party [ ]

Subscriber/Member Name:_____ DOB:_____

Whiat is patient relationship to subscriber? _____ Gender: M / F

Primary Insurance Company:_____ Begin Date:_____

Subscriber / Member Number: _____ Group Number:_____

Check if same as responsible party [ ]

Subscriber/Member Name:_____ DOB:_____

Whiat is patient relationship to subscriber? _____ Gender: M / F

Secondary Insurance Company:_____ Begin Date:_____

Subscriber / Member Number: _____ Group Number:_____

TAMPA BAY DIABETES THYROID AND ENDOCRINOLOGY CENTER

DR. AJAY VARANASI MD, FACP, FACE

Patient Information & Medications

Today's Date:_____

Patient Name:_____ **DOB:**_____

Phone Number:_____

Pharmacy Name:_____

Pharmacy Address:_____**Pharmacy Phone:**_____

Primary Care Physician:_____

Referring Physician:_____

Other Specialists Currently Seeing:_____
_____
_____
_____

Allergies:_____
_____
_____

List of Medications & Supplements Currently Taking:

_____
_____
_____
_____
_____

_____

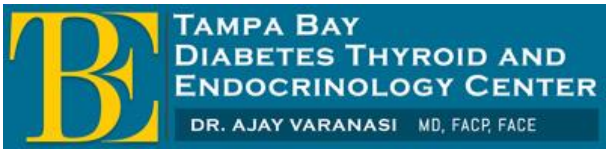
_____

_____

_____

_____

_____



New Patient Medical History Form

Name:_____ DOB:_____ Age:_____

CHECK ALL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

___Diabetes ___Hypertension ___Elevated Cholesterol ___Cancer

___Thyroid Disease ___Osteoporosis ___Other (specify)_____

HOSPITALIZATIONS/SURGERIES/PROCEDURES

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

FAMILY HISTORY

Father: Living_____ Deceased_____ Cause of Death_____
Mother: Living_____ Deceased_____ Cause of Death_____
Grandfather Paternal: Living_____ Deceased_____ Cause of Death_____
Grandmother Paternal: Living_____ Deceased_____ Cause of Death_____
Grandfather Maternal: Living_____ Deceased_____ Cause of Death_____
Grandmother Maternal: Living_____ Deceased_____ Cause of Death_____

Has any Parent/Grandparent/Sibling had the following: (which relative?)

Diabetes_____ Thyroid Cancer_____ Arthritis_____

Breast Cancer_____	Colon Cancer_____	Depression_____
Lung Cancer_____	Prostate Cancer_____	Alcoholism_____
Ovarian Cancer_____	Heart Disease_____	Colon Polyps_____
Osteoporosis_____	Stroke_____	Glaucoma_____
Bleeding Disorder_____	Kidney Disease_____	Melanoma_____
Other Cancer_____		

Do you smoke? __Y/N__ Packs per day___ Years___ Quit (when?)_____

Do you drink alcohol? __Y/N__ Drinks per week?_____

Do you drink Coffee/Tea? __Y/N__ Cups per day?_____