



# Madhavan Pisharodi, M.D.

Board Certified: Neurological Surgery • Assistant Professor, Neurosurgery, UTMB, Galveston

## Cathryn L. Garnett, M.S.N., C.N.S., F.N.P.

Family Nurse Practitioner

### Registration Form

#### Patient Information

Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Ph (Home): \_\_\_\_\_ Ph (Work) \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact (friend / family member not living with you):

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Referring / Treating Physician Information:

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this injury related to a motor vehicle accident?

Yes

No

Did your injury occur at a Retail / Department Store?

Yes

No

Is this a work related injury?

Yes

No

If you answered yes to either question, please answer the following questions:

- What is the date of injury? \_\_\_\_\_
- Is there an attorney handling your case? \_\_\_\_\_
- Please provide the Attorney's name and phone number: \_\_\_\_\_

#### Employer Information:

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### Insurance Carrier:

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Policy Holder Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Policy Holder Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize payment of benefits to Dr. Pisharodi for services rendered for the treatment of my injury. I also authorize the release of any medical information necessary to process any claim for services rendered to me by Dr. Pisharodi.

Patient  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Date / Fecha: \_\_\_\_\_

(English)

I, \_\_\_\_\_ agree to pay all medical expenses owed to Dr. Pisharodi. I hereby assume full compliance and promise to settle all expenses incurred thereof, following the legal settlement regardless of the fact that the settlement covers the medical expenses or not.

I, \_\_\_\_\_ hereby give permission that my photograph be taken as a record for my chart.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

(Español)

Yo, \_\_\_\_\_ tomo toda responsabilidad por cobros y pagos medicos al Dr. Pisharodi. To aseguro que toda deuda sera pagada por completo, al terminar mi caso en la corte, independientemente de que mi caso en la corte cobra mis gastos medicos o no.

Yo, \_\_\_\_\_ doy permiso para que se me tome una fotografia para mi expediente.

\_\_\_\_\_  
Firma del Paciente

\_\_\_\_\_  
Testigo



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**Release of Medical Records**

I, \_\_\_\_\_ authorize Pisharodi Clinic to release any and all medical information including hospital records, test results, diagnosis, treatments, or any other related information.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



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**Pre-Existing Condition Questionnaire**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

1. What Medical Condition are you seeing Dr. Pisharodi for? \_\_\_\_\_

2. Have you been treated for this condition by another doctor? 

Yes	No
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- If yes, please give the following information:

Doctor's Name: \_\_\_\_\_ Doctor's Specialty: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

3. For how long have you had medical coverage with your present insurance carrier? \_\_\_\_\_

4. If you have had less than 12 months of medical coverage with your present insurance carrier, please advice which insurance company, if any, insured you before?

Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Coverages Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

5. Are you aware of any pre-existing clause contained in your present insurance policy that excludes or denies medical benefits for a certain period of time? 

Yes	No
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- If Yes, for how long? \_\_\_\_\_ Date of hire: \_\_\_\_\_

I certify, the information provided on this sheet is true and accurate to the best of my knowledge and belief. I am solely liable for all the medical expenses that are connected with my present medical condition. I agree to pay all medical expenses owed to Dr. Pisharodi if the insurance company doesn't cover my present condition due to any reason.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Patient: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

**Madhavan Pisharodi, M.D., P.A.  
3475 West Alton Gloor, Suite A, Brownsville, Texas 78520**

If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make out the check to me mail it to as follows:

**c/o Madhavan Pisharodi, M.D., P.A.  
3475 West Alton Gloor, Suite A, Brownsville, Texas 78520**

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this assignment shall be considered as effective and valid as the original.

I also authorize doctor to initiate a complaint to the Insurance Commissioner and/or Texas Department of Insurance for any reason on my behalf.

Policy Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Claimant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Insurance Company Compliance Form**

Date: \_\_\_\_\_

We (Pisharodi Clinic), filed the attached claim form with \_\_\_\_\_  
Insurance Company on \_\_\_\_\_. It has not been paid or denied.

Please accept this as a formal written complaint against the \_\_\_\_\_  
Insurance Company.

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

I filed the attached claim form with \_\_\_\_\_ Insurance Company  
on \_\_\_\_\_. It has not been paid or denied.

Benefits were assigned to Madhavan Pisharodi, M.D., P.A., and, as of today's date,  
payment has not been received. I am responsible for payment of this bill.

Please accept this as a formal written complaint against the \_\_\_\_\_  
Insurance Company.

Patient's Signature \_\_\_\_\_



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### Patient Consent Form

#### Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Madhavan Pisharodi, M.D., P.A., or his office staff, may use and disclosure protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Madhavan Pisharodi, M.D., P.A., or his office staff's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Madhavan Pisharodi, M.D., P.A., or his office staff, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Madhavan Pisharodi, M.D. Privacy Officer at 3475 West Alton Gloor, Suite A, Brownsville, Texas 78520.

With my consent, Madhavan Pisharodi, M.D., P.A., or his office staff, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With my consent, Madhavan Pisharodi, M.D., P.A., or his office staff, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Madhavan Pisharodi, M.D., P.A., or his office staff, may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Madhavan Pisharodi, M.D., P.A., restricts how he uses or discloses my PHI to carry out my TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I'm consenting to Madhavan Pisharodi, M.D.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extend that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, Madhavan Pisharodi, M.D. may decline to provide treatment to me.

Patient's Name: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature or Legal Guardian

I acknowledge that I have been provided with a "Notice of Privacy Practices" and a "Medicare/Medicaid Assurance Notification Form" as required by the Health Insurance Portability and Accountability Act of 1996. (HIPPA)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date:



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### **Disclosure**

If the patient requires any surgery, there is the possibility that Dr. Pisharodi may use UNIMAX, RADIX, or SARAL System which are FDA approved following Research and Development by Dr. Pisharodi. There could be conflict of interest because Dr. Pisharodi will be using a device invented by him.

Patient Name: \_\_\_\_\_

Witness By: \_\_\_\_\_

Date: \_\_\_\_\_