DR. ARUNACHALAM SEVUGAN, M.D.
14333 LAUREL BOWIE ROAD STE 202
LAUREL, MARYLAND 20708
PHONE: (240) 558-7206
FAX: (240) 558-7207

PATIENT REGISTRATION FORM

First Name: ________________________________ Last Name: _____________________________________ M.I.: ________

Sex: ☐ Male ☐ Female Date of Birth: ______/______/______ Age: ___________ SSN# (optional): ________________________

Address: ____ City: _________________ State: _______ Zip: _______________

Cell Ph: ________________ Home Ph: ________________ Work Ph: ________________ Email: ________________________

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced ☐ Other
Race: ☐ White ☐ African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Mixed ☐ Other / ☐ Hispanic ☐ Non-Hispanic

Occupation: ______________________ Employer: ______________________ Work Address: _________________________

Emergency Contact Information: I give permission to discuss my condition with persons listed below as need or in an emergency

#1 Name: ________________________________ Relationship: _____________________ Phone: ______________________

#2 Name: ________________________________ Relationship: _____________________ Phone: ______________________

Preferred Pharmacy:

Name: ____________________________________ Address: ____________________________ Phone: _________________

Insurance Information:

Primary Insurance Company: ______________________________Member ID:__________________ Group #: ______________

Policy Holder First Name: ________________________________ Last Name: ________________________ D.O.B.: _________
Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance Company: ____________________________Member ID:__________________ Group #: ______________

Policy Holder First Name: ________________________________ Last Name: ________________________ D.O.B.: _________
Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Referred By: Name: ____ Relationship:________________________________

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed plan and assign directly to Sevugan MD, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and will pay the balance if not paid by insurance in the allowed 60 days. I hereby authorize Sevugan MD, LLC to release all information necessary to secure payment of benefits, including the diagnosis and records of any treatment or examination. I authorize the release of this information to third party payers, the physician's billing service and/or other health practitioners. I understand that unpaid balances may be turned over to a third party for collection. I authorize the use of this signature on all insurance submissions. I agree that all co-payments will be paid at the time of service, in accordance with the contracted insurance carrier agreement. This shall remain valid until written notice is given by me to the office revoking this authorization.

Patient/Guardian Signature: ____ Date: ________________

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OFFICE POLICIES

Thank you for choosing Sevugan MD, LLC for your healthcare needs. We are committed to providing excellent quality comprehensive care in a warm and welcoming environment. The dedicated staff at Sevugan MD, LLC are focused on providing our patients with the highest quality medical care while paying close attention to and nurturing each patient's individual needs. For any questions please call us at 240-558-7206, Monday - Friday 9:00AM to 5:00PM. For medical emergencies call 911 or go to the nearest emergency room.

Appointments & Forms
All office visits are by appointment only. Please turn off your cell phone beyond the waiting room due to sensitive medical equipment. For all forms completion, please bring your form to your appointment. Forms may take up to 2-4 days to be completed after your visit if lab work is required. Forms filled out without an office visit may incur a fee of $25.00. If you are a new patient, we ask you to arrive 15 minutes prior to your appointment to allow additional time for gathering all of the needed information. New patients please also ask for a "Medical Records Request Form" to request your records from your previous physician. If you are requesting us to send a copy of your medical records to another facility, please fill out the requested form. Please note you may be billed separately for sending these records.

Cancellation Policy & Late Policy:
If you are unable to keep a scheduled appointment, please give 24 hours advance notice to ensure that you will not be charged for the appointment. There will be a $50.00 cancellation or no-show fee. Cancellation/No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval. When our patients arrive on time it helps the providers stay on schedule. If you arrive more than 15 minutes late for an appointment, you may be asked to reschedule.

Medications & Refills
Medication refills are reviewed during the hours of 9am to 5pm, Monday through Friday. Requests are filed within 24-48 hours. Chronic medical conditions will require an office visit every 3 months unless stated otherwise by your physician.

Labs & Diagnostic Test Results
Please note that some tests take up to two weeks for results . If you need to speak with someone concerning your results, please call the office during business hours.

Insurance
We urge you to familiarize yourself with the specifics of your insurance plan. Please be aware that a medical service may go towards your deductible, copay or coinsurance. We understand that your health insurance information may change from time to time; however, it is your responsibility to contact our office immediately should any changes occur. Should you fail to provide us with the most accurate information in a timely manner you will be responsible for and billed for all charges that result in non-payment or denial by your insurance company. An invoice will be sent to you and payment is expected within 30 days of receipt.

Your insurance company may limit where you can get blood work done or which labs will be covered. Please be advised that your insurance company will not cover your lab work if you use the wrong lab. Please contact your insurance company to assure you do not encounter any unexpected charges or fees. Sevugan MD, LLC will not be responsible for any unpaid balances in the event that you use the wrong laboratory. The patient is responsible for any balances from the laboratory according to the patient insurance's plan for any blood work and labs that were collected in the office and sent out to the laboratory.

Billing
For any questions about your bill, please contact the office. Check your statement carefully when you receive it. Let us know promptly if there is a problem. Balances and deductibles are due within 30 days of the receipt of your billing statement. Co-pays and past due balances are required at the time of service. We are contractually obligated to collect any copay, co-insurance and/or deductible and cannot "write-off" any portion of these debts. In addition, your contract may require that we report any willful non-payment of co-insurance, copays or deductibles to your insurance carrier. Any balance over 180 days old will be referred to a collection agency and will no longer be handled by this office.

Confirm Receipt of HIPAA
I have received a copy of Sevugan MD, LLC Notice of Privacy Policy. Sevugan MD, LLC reserves the right to revise its notice of privacy policy at any time. A revised notice may be obtained by forwarding a written request to Sevugan MD, LLC.

I have read the above and understand and accept the terms of the patient responsibility/financial agreement. I also understand that i will be responsible for any and all collection fees should I fail to make payments in a timely manner.

Patient Printed Name: ____ Date of Birth: ___________________________

Patient Signature: ____ Today's Date: ___________________________

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NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one more health care providers. An example of this would be a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2021 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Policy and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Polices from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at 240-558-7206 with any questions you may have.
I acknowledge that I have received a copy of the Notice of Privacy Practices.

____________________	____________________	__________
Printed Name	Signature of Patient or Guardian	Date

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DISCLOSURE CONSENT

Patient Name: ________________________________ Date of Birth: ____________________

I wish to be called using the below number(s) regarding my test results, treatment plans, referrals and/or billing and payment information. The best telephone number(s) to reach me are:

Phone No: _____________________________________ ⬜Home ⬜Cell ⬜Work ⬜Other

Phone No: _____________________________________ ⬜Home ⬜Cell ⬜Work ⬜Other

⬜I DO give permission to leave relevant medical information on my answering machine or voicemail.

⬜I DO NOT give permission to leave relevant medical information on my answering machine or voicemail.

I authorize Sevugan MD, LLC to disclose my Protected Health Information either verbally or via phone, fax, email or paper copy to:

Name: ____________________________ Relationship to Patient: _______________________

Address: ____________________________________Phone: __________________________

I understand that I have the right to revoke my permission at any time. I understand this permission remains in effect until the time I revoke it in writing.

Patient Signature: ______________________________________ Date: _______________

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

RELEASE INFORMATION FOR:

Patient Name: _______________________________________ Date of Birth: _________________________

Address : ____ Social Security #: ______________________

Home Phone: ______________________Work: ______________________ Cell: _______________________

RELEASE INFORMATION FROM:

Name/Organization: ____

Address: ____

Phone: _______________________________________ Fax: _______________________________________

Purpose of disclosure: ⬜ Continuity of Care ⬜ Other ____________________________________

I authorize release of my complete records (including but not limited to diagnosis, lab test, prognosis, treatment and billing for all conditions) for:

⬜ **All Medical Records** ⬜ **Last 3 Years Only** ⬜**Other (Explain) _____________**

⬜**I DO** ⬜**I do NOT** **authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.**

SEND INFORMATION TO:

SEVUGAN MD, LLC
Dr. ARUNACHALAM SEVUGAN
14333 LAUREL BOWIE ROAD, STE 202
LAUREL MD, 20708

I do hereby authorize you to release my medical information to Dr. Arunachalam Sevugan. This health information may be used to enable the person(s) I authorized to know and understand my condition and my treatment or treatment options, for treatment or consultations, for claims payment purposes, or related reasons. I understand that I have the right to revoke this authorization, in writing, at any time, except where users or disclosures have already been made based upon my original permission.

____ ________________

Signature of Patient or Guardian Date