Pandya Medical Center

Dear New Patient,

Our TEAM is delighted that you have chosen **Pandya Medical Center ("PMC")** as your primary care home. We would like to take this opportunity to welcome you to our practice and **THANK YOU** for choosing our providers to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care for the entire family, focusing on wellness and prevention. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our team of health professionals include Doctors, Nurse Practitioners, Physician Associates, Nutritionist, Medical Assistants, and Practice Support Staff, all working together to provide for your health care needs.

Please take a moment to read over this information about services we offer:

Regular Office Hours (Monday to Friday 8am-5pm):

- ✔ For appointments, cancellations, and prescription refills, please call our office during regular office hours.
  - We do have a No-Show Policy and require 24-to-48-hour notification if you need to cancel or reschedule based on type of appointment scheduled. (See Financial Policy)
- ✔ **For non-urgent matters, medication refills, lab results, pre-op evaluations and physicals; appointments are the best way to go over questions and concerns**.
- ✔ Please note: **if your insurance requires a referral to a specialist,** we will need to see you in the office before we can proceed with the referral. This is required by your insurance and is our office policy. We will not be able to proceed with the referral without an office visit for a face-to-face evaluation.
- ✔ Appointments may be required to review imaging (CT, MRI, Ultrasound etc.,) as some do require additional intervention, evaluation and/or discussion.

Patient Portal (for non-urgent communication):

- ✔ Our secure portal allows patients to make/request appointments, medication refills, view labs and imaging results.
  - All controlled medications require an office visit for refills. (Phentermine, ADHD medications, pain medications, etc.)
  - Any request to change dosage of a medication will require an appointment.
  - Please allow 48 to 72 hours for medication refill requests to be completed.
- ✔ The portal allows patients to see visit summaries, records, billing statements.
  - Lab results are posted directly into your patient chart and may be obtained quickly through the Patient Portal after being reviewed by the provider.
  - Please remember that Portal Messages do NOT replace office visits
    - If you have multiple clinical questions, this usually warrants an office visit.
      - You may schedule an appointment with any of our providers at ***770-709-6922***.
  - Please refrain from sending multiple messages regarding the same inquiry, as this will delay us getting a response back to you expediently.
  - All messages will be addressed within 48 to 72 business hours.
- ✔ You may also pay your bill online through our secure patient portal.
- ✔ **IMPORTANT**: If you have a new symptom/issue, please schedule an appointment.

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Tele-Medicine (personalized doctor consultations via the Internet):

There may be times when you are out of town or due to other circumstances are not able to come to our office and need urgent care. PMC offers tele-medicine appointments as a convenient way to be treated in the comfort of your home, office, or hotel using your computer/tablet/smartphone device. We provide this service for certain acute and chronic conditions.

- ✔ Please check with your insurance regarding Telemedicine coverage.
  - ➢ If your insurance does cover Telemedicine, your insurance will be billed as other office visits and co-pays, coinsurances and deductibles may apply.

After Hours/Urgent Care:

A medical provider is available after hours for telephone consultation for **urgent medical needs**. Call our office and our on-call provider will be paged for you. **Please note, if you are having a life-threatening issue, please call 911 and go to your nearest emergency room.**

- ✔ For scheduling appointments, prescription refill or test results, please call our office during regular business hours or submit your request via the patient portal and a staff member will address your request next business during regular business hours.
- ✔ Every effort is made to see our patients for medical problems during daytime hours. Our schedulers are available during business hours and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care.

Registered Dietitian and Nutritionist: We have a nutritionist on staff to help you create personalized dietary goals to help with: Weight Loss, Wellness & Preventive Nutrition, Polycystic Ovarian Syndrome, Autoimmune conditions, Cholesterol and Triglyceride Reduction, Pre-diabetes, Diabetes, High Blood Pressure, and Chronic Disease Management, etc.

Medical Grade Supplements: We recommend Science-Based Products from reputable nutraceutical companies because they meet the highest standards for research and quality manufacturing to help make natural approaches safer and more effective.

Myer's IV Infusions: We provide intravenous (I.V.) drips of certain vitamins to help strengthen your immune system, detoxify your body, and boost your overall health. Please see one of our providers to determine if you would benefit from these infusions.

In-house Ultrasounds: We provide ultrasounds for our patients in our office including Echocardiogram, Abdominal Ultrasound, Thyroid Ultrasound, Kidney Ultrasound, etc. as a convenience for our patients on select days.

Thank you again for choosing Pandya Medical Center as your medical home and we look forward to working together.

Sincerely,

Pandya Medical Center Team

Pandya Medical Center

Patient Registration Form

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM, PROVIDE A GOVERNMENT ISSUED PICTURE ID AND INSURANCE CARD BEFORE SEEING A PROVIDER.

LAST NAME: _____ FIRST NAME: _____ M.I. _____

STREET ADDRESS: _____ _____ CITY: _____

STATE: _____ ZIP _____ PHONE: (C)_____(W)_____

___ Phone
___ Email
___ Mail

EMAIL ADDRESS: _____ Preferred Means of Communication (Please Check All Applicable)

BIRTH DATE: _____

LEGAL SEX (M) ___ (F) ____ MARITAL STATUS (please circle one**): Single, Married, Widowed, Divorced**

RACE (please circle): **African American, Asian, Asian American, Black, Indian/South Asian, White, Other Race _____, Refuse**

EMERGENCY CONTACT NAME: _____ PHONE: _____
RELATIONSHIP: _____

INSURANCE CARRIER _____ INSURED'S SSN _____-_____-_____

INSURANCE BILLING ADDRESS:	**Relationship to Patient:**
Insured's Employer Name:	**Insured's Date of Birth:**
Insured's Policy Number:	**Insured's Group Number:**

SECONDARY INSURANCE CARRIER _____ INSURED'S SSN _____-_____-_____

INSURANCE BILLING ADDRESS:	**Relationship to Patient:**
Insured's Employer Name:	**Insured's Date of Birth:**
Insured's Policy Number:	**Insured's Group Number:**

NAME: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____
PHARMACY INFORMATION:

Pandya Medical Center

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
FATHER'S NAME: _____ PHONE: _____
MOTHER'S NAME: _____ PHONE: _____

Authorized Signers Initials Confirming the Above is accurate _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In order to maintain continuity of care, I give permission to Pandya Medical Center to release my medical records to any specialists, hospital or medical facilities associated with my care plan. I understand that Pandya Medical Center abides by HIPAA regulations and that only the records pertinent to the visit and my health will be released.

Authorized Signer's Printed Name: _____ Relationship: _____

Authorized Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize to receive treatment by Pandya Medical Center and its staff for the person named as the patient on this form. I authorize all insurance benefits to be paid directly to Pandya Medical Center.

Authorized Signature: _____ Date: _____

RELEASE OF BILLING INFORMATION FOR PAYMENT

I give my permission for Pandya Medical Center ("PMC") to bill my health insurance company for services provided to the patient's name listed on this form. I agree and acknowledge that my signature on this document authorizes PMC to submit claims for service rendered without obtaining my signature on each and every claim to be submitted for patient name listed on this form and that I will be bound by this signature as though the undersigned had personally signed the particular claim.
During the course of treatment for the patient's name listed on this form at PMC, I understand that there may be occasions for charges of non-face to face visits, treatment recommendations, and/or review of records. I give my permission for PMC to bill my insurance company for these services and any amount deemed patient responsibility by the insurance company will be billed to me accordingly.

Authorized Signature: _____Date: _____

Pandya Medical Center

Notice of Privacy

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

If you have any questions about this Notice, please do not hesitate to ask.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and/or future physical or mental health or condition or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our offices who are involved in your care and treatment for the purposes of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice. We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object:

- ✔ Required by law
- ✔ Public health reasons
- ✔ Communicable diseases
- ✔ Required by the FDA
- ✔ Abuse or Neglect of a Patient
- ✔ Workers' Compensation
- ✔ Inmates under Treatment

2. **Your Rights**

- ✔ You have the right to inspect and copy your protected health information. As permitted by federal and/or state law, we may charge you a reasonable copy fee for your records.
- ✔ You have the right to request a restriction of your protected health information and ask us not to disclose your information to certain individuals.
- ✔ You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.
- ✔ You may have the right to have your provider amend your protected health information, if you believe it is incomplete or inaccurate.
- ✔ You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
- ✔ If you wish to receive an email communication regarding your health information or records, you acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible security breach.

Authorized Signer's Initial Acknowledging Receipt of the Above _____

Pandya Medical Center

I authorize the following to have access to my Protected Health Information:

Printed Name	Relationship
Printed Name	Relationship
Printed Name	Relationship

I give my permission for Pandya Medical Center and its staff to leave messages/communications about my health, medical results, lab results or appointment at the following numbers and/or email address:

Home: _____

Mobile/Cell: _____

Work: _____

Email Address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I, _____, have received a copy of Notice of Privacy from Pandya Medical Center.

Signature of Patient or Authorized Signer: _____ Date: _____

Pandya Medical Center

Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, do not hesitate to ask a member of our staff. We will be more than happy to assist you.

1) On arrival, please be sure to check in at the front desk and present your current insurance card at every visit along with proper identification.
    a. Proper identification would be defined as a government issued form of identification (passport, driver's license, state identification).
    b. If the insurance information provided to us is not correct, terminated and/or we are not listed as the Primary Care Physician ("PCP"), you will be responsible for payment of the visit at the time of service.
2) It is your responsibility to inform your insurance company that you would like to change your PCP to one of our providers at Pandya Medical Center. If this is not done, you will be responsible for all charges.
3) We file claims on behalf of you as a courtesy. If claims are unpaid after 90 days, these claims will be referred to a collection agency. Please be sure to follow up with your insurance company regarding claim status. You are responsible for any balance on your account.
4) It is your responsibility to understand your benefit plan and what services will apply to a deductible and/or if a co-pay is required.
    a. If your plan has a deductible and coinsurance benefit with NO Copay, you will be responsible for any deductible that has not been met.
        - If your deductible is unmet and exceeds $100.00, you will be required to pay $100.00 towards your unmet deductible and you will receive an invoice for any additional amount due once insurance has processed your claim.
5) Not all services provided by our office are covered by every insurance plan. Any service determined to not be covered by your insurance plan will be your financial responsibility.
6) All patient balances are billed immediately on receipt of your insurance plan's explanation of benefits ("EOB"). Your financial responsibility will be due within 10 business days of the receipt of your bill.
7) For scheduled appointments, prior balances must be paid prior to visit.
8) We do require a 24-hour to 48-hour notice for cancelling any appointments, depending on the type of appointment as described below. Failure to provide the proper notification may result in a charge to your account, our fees vary based on the type of appointments as described below.
    a. Office Visit or IV Infusion Visit: 24-hour Notice is required, or a $75 Fee will be applied
    b. Nutritionist Visit: 48-hour Notice is required, or a $75 Fee will be applied
    c. Ultrasound Visit: 48-hour Notice is required, or a $75 Fee will be applied
    d. No Show or No Notification: a $75 will be applied
    e. Repeat No Show or No Notifications may result in the dismissal from our Practice.
9) A $35 fee will be charged for any checks returned for NSF, plus any bank fees incurred by Pandya Medical Center because of this transaction.
10) If you or your child has a special school, camp, or sport form that you need completed by your Provider, there is a $25 charge per form ($175.00 for FMLA Forms.) Payment is due when the forms are dropped off and forms will be completed within a week.
    a. If you or your child has not had a physical or been seen by one of our Providers within 1 year from the time of request, then you or your child will be required to make an appointment to be seen so accurate health information can be provided on the respective forms.

I have read and understand this financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____

Responsible Party Name Printed

_____ _____

Responsible Party Signature Date

*Pandya Medical Center Phone: 770-709-6922 and **FAX: 770-709-6910***

Pandya Medical Center

Financial Disclosure and Consent for Telemedicine

We offer telemedicine as an essential tool to help patients receive better access to health care. Due to current changes with insurance coverage for telemedicine appointments, these services **may not** be covered by your insurance.

Consent for Telemedicine Treatment:

- I voluntarily request and give permission (consent) for Pandya Medical Center providers to provide medical care and treatment using audio/visual telemedicine technology when deemed appropriate.
- I understand that an alternative to telemedicine treatment is to receive medical care in-person at any Pandya Medical Center locations.

Financial Agreement:

- I acknowledge that as a courtesy, the practice will bill my insurance company for services provided to me.
- I agree and understand that I am responsible for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance associated with telemedicine visits, in accordance with my insurance company's policies.
- ***If my insurance company does not cover telemedicine, the price for a telemedicine visit is $115.***

By signing below, I confirm that I have read, understand, and agree to the terms outlined in this consent form.

Signature: _____

Date: _____

*Pandya Medical Center Phone: 770-709-6922 and **FAX: 770-709-6910***

Pandya Medical Center

Release of Medical Records

FAX: 770-709-6910/www.pandyamedicalcenter.com

Location: ☐ Alpharetta ☐ Braselton ☐ Cumming ☐ Dawsonville ☐Gainesville ☐ Lawrenceville ☐ Johns Creek

Patient Full Legal Name:

Last Name First Name Middle

Date of Birth:

Mailing Address:

Phone Number:

☐ **OBTAIN** my information **FROM**: (as indicated below)
☐ **RELEASE** my information **TO**: (as indicated below)

I authorize Pandya Medical Center to:
(Please Check One)

NAME OF PROVIDER/PRACTICE/FACILITY:

Address:

Phone:

Fax:

Email:

_____ All Records
_____ Last Office Visit Note
_____ Last Blood Work Results
_____ EKG, Stress Test, ABI, Cardiac Cath
_____ X-Rays/CT/MRI/Ultrasound
_____ Immunization Records
_____ Other: _____

Information Requested:
(Please Check)

Authorized Signature Date

If you wish to receive an email communication regarding your health information or records, you acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible breach.

Pandya Medical Center

Ambient AI Scribe Patient Consent

Practice: Pandya Medical Center

Pandya Medical Center may use Ambient AI Scribe technology to securely assist providers with medical charting. This tool may capture audio during your visit and convert it into a clinical note stored in your electronic health record.

How Recording Works:

Ambient AI Scribe uses a secure microphone on a provider's device to capture **real-time audio** during your visit. The audio is processed instantly to generate visit note documentation.

- The system records **only** during your active visit.
- Audio is used for real-time transcription.
- Recordings are encrypted and handled in a HIPAA-compliant manner.

How Your Information Is Used:

- Audio from your visit may be processed to create accurate documentation and provide you with a visit summary
- Data is encrypted and handled in a HIPAA-compliant manner.
- Audio is not stored long-term unless needed for clinical accuracy.
- No information is used for marketing or non-clinical purposes.

Your Rights:

- You may decline or stop the use of the AI Scribe at any time.
- Your care will **not** be affected by your decision.

Consent

By signing below, I acknowledge that I understand and agree to the use of Ambient AI Scribe during my visit and that I may withdraw consent at any time.

Patient Name: _____

Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

*Pandya Medical Center Phone: 770-709-6922 and **FAX: 770-709-6910***