M.P. VEERA MD PA
CONSULTATION BY REFERRAL ONLY
BOARD CERTIFIED IN GASTROENTEROLGY & INTERNAL MEDICINE

MP VEERA MD PA PATIENT WELCOME LETTER

M.P. VEERA MD PA
DR. M.P. VEERABAGU, MD, AGAF
NOON
130 PERPETUAL SQUARE, ANDERSON, SC 29621

OFFICE HOURS: MONDAY-FRIDAY: 8 AM-12 NOON
MONDAY-THURSDAY: 1 PM -5 PM/CLOSED FRIDAY 12

PHONE:(864)224-8689 FAX:(864)222-1303

PATIENT NAME: ______________________________ **APPOINTMENT DATE/TIME:** ____________________

WELCOME TO OUR GASTROENTEROLOGY PRACTICE. YOUR FIRST VISIT **IS AN OFFICE CONSULTATION VISIT ONLY**. YOUR PROCEDURE AND ANY RELATED PREPARATION WILL BE DISCUSSED ON A ONE-ON-ONE BASIS WITH YOU DURING THIS VISIT**.** BRING THE FOLLOWING FOR YOUR VISIT.

- ATTACHED FORMS ALL FILLED OUT
- **PHYSICIAN REFERRAL FORMS AS PER YOUR INSURANCE PLANS WHEN REQUIRED TO SEE A SPECIALIST IS YOUR RESPONSIBILITY**
- **PLEASE BE CONSIDERATE TO OTHER PATIENTS WAITING TO SEE OUR PROVIDERS. CALL US IMMEDIATELY TO CONFIRM, RESCHEDULE OR CANCEL YOUR APPOINTMENT AT 864.224.8689.**
- CURRENT MEDICATIONS-BOTH PRESCRIPTIONS AND OVER-THE-COUNTER, including YOUR MAIL ODER PHARMACY INFORMATION
- THE LABORATORY NAME AND PHONE # WHERE YOUR INSURANCE COMPANY IS IN NETWORK
- **BILL PAYMENT:** WE GENERALLY FILE ON YOUR BEHALF WITH YOUR INSURANCE COMPANY. HOWEVER, INSURANCE REIMBURSEMENTS ARE NOT A SUBSTITUTE FOR ALL PAYMENTS DUE.
- CAUSES FOR DISMISSAL FROM PRACTICE INCLUDE BUT NOT LIMITED TO - SAME DAY CANCELLATIONS, NOT KEEPING APPOINTMENTS, MEDICAL AND BILL PAYMENT NON-COMPLIANCE.

YOUR INSURANCE ELIGIBILITY WAS CHECKED ON: ______________ **Ins:** __________________________
YOU ARE: IN NETWORK/ OUT OF NETWORK/ CASH OR SELF PAY

PLEASE BRING YOUR DEPOSIT TO THIS APPOINTMENT. SEE DETAILS BELOW.

THIS VISIT ______________
PRIOR BALANCE ______________ **(Not inclusive of pending charges on recent services)**

Procedure(s) scheduled during office visit
PROFESSIONAL FEE FOR COLONSCOPY ______________ **(Deductible/Co-Insurance/Copays/Cash or Self pay)**
PROFESSIONAL FEE FOR EGD ______________ **(Deductible/Co-Insurance/Copays/Cash or Self pay)**
OTHER PROFESSIONAL SERVICES: __________ ______________ **(Deductible/Co-Insurance/Copays/Cash or Self pay)**

DEPOSIT DUE ______________ ***AT THE TIME OF THIS VISIT.***

PATIENT ALERT: AFTER VISIT WITH PROVIDER, SERVICES/DEPOSITS MAY BE UPDATED AT CHECK OUT WHILE SCHEDULING PROCEDURES. FINDINGS DURING YOUR ACTUAL PROCEDURE(S) ENCOUNTER MAY CHANGE THE ABOVE DEPOSIT AS WELL. ALL OF THE ABOVE WILL BE REFLECTED IN YOUR BILLING STATEMENT AFTER SERVICES ARE RENDERED SHOWING FURTHER AMOUNTS DUE OR REFUNDS FROM PRACTICE.

FOR YOUR ESTIMATED COSTS NOT RELATED TO MP VEERA MD PA (FACILITY, LABS, BIOPSIES):
Upstate Endoscopy, LLC (Upstate) Facility procedures: Call 864.512.6555
Upstate procedure Anesthesia call Anesthesia Services of Anderson, SC @ 864.225.4601
Upstate procedure's Biopsy Readings, IF NEEDED, taken during procedure-call Piedmont Pathology @ 864-226-1558
AnMed Facility Procedures, Anesthesia, Biopsy/labs and other fees: Call Anmed Financial Services @ 864-512-1417.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________

M.P. VEERA MD PA
PATIENT WELCOME SHEET/CONSULTATION BY REFERRAL ONLY
BOARD CERTIFIED IN GASTROENTEROLGY & INTERNAL MEDICINE

ADDITIONAL INFORMATION PERTAINING TO YOUR TREATMENT:

REFILLS: PRIOR AUTHORIZATIONS FOR MEDICATIONS REQUIRE US TO REVIEW YOUR CHART AND SUBMIT INFORMATION TO YOUR INSURANCE COMPANY FOR APPROVAL. IT MAY TAKE SEVERAL DAYS TO GET A RESPONSE. IT IS RESPONSIBILITY OF EACH PATIENT TO ASK FOR TIMELY REFILLS AND UPDATE THEIR MEDICATION LIST & INSURANCE INFORMATION AT EACH OFFICE VISIT. REFILLS ON MAINTENANCE MEDICATIONS CAN BE OBTAINED BY CALLING YOUR PHARMACY. THE PHARMACY WILL THEN CONTACT US.

CONTROLLED SUBSTANCES WILL BE REFILLED ONLY DURING REGULAR OFFICE HOURS.

TEST RESULTS: THE NATURE AND COMPLEXITY OF THE RESULTS WILL DETERMINE HOW THEY WILL BE REPORTED TO YOU. POSSIBILITIES INCLUDE: OFFICE VISITS, MAIL, TELEPHONE CALL OR PATIENT PORTAL/" EPIC MYCHARTS".

LABS: OCCASIONALLY, WE ORDER LABS WHICH ARE DONE AT OTHER THIRDPARTY LAB FACILITIES THAT MAY BE OUT-OF-NETWORK OR THE ORDER MAY BE A NONCOVERED SERVICE FOR INSURANCE. PLEASE DISCUSS THESE SPECIFICS WITH THE LAB AND YOUR INSURANCE(S) PRIOR TO YOUR LABS BEING DRAWN.

MP Veera MD PA
864.224.8689
Patient Information Sheet

IMPORTANT NOTICE
Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank you.

PATIENT INFORMATION

Full Name: ____ Social Security #: ____

Date of Birth: ____ Name you wish to be called: ____

Legal Sex: (as on your driver's license) ____

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Transgender Female (male-to-female)
- ☐ Transgender Male (female-to-male)
- ☐ Other

Sex at Birth:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Unknown
- ☐ Uncertain
- ☐ Not recorded on birth certificate

Sexual Orientation:
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Choose not to disclose
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else

Mailing Address: ____

City, State, Zip: ____ County: ____

Street Address: ____

City, State, Zip: ____ County: ____

Home Phone # ____ Work Phone #: ____ Mobile #: ____

Email Address: ____ I DON'T HAVE EMAIL NO THANKS

Marital Status:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Significant Other
- ☐ Single
- ☐ Single
- ☐ Widowed
- ☐ Other
- ☐ Unknown

Do you need an Interpreter? YES NO

Language Preference: ____

Written Language Preference: ____

Religion: ____

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian Indian
- ☐ Asian
- ☐ Native Hawaiian / Other, Pacific Islander
- ☐ Black / African American
- ☐ White
- ☐ Unknown
- ☐ Declined

Ethnicity:
- ☐ Not Hispanic Latino/a or Spanish origin
- ☐ Colombian
- ☐ Cuban
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican, Mexican American or Chicano/a
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Declined to Answer
- ☐ Unknown

Primary Care Provider (PCP) Name: ____

Emergency Contact Name and Relationship: ____

Emergency Contact Phone #: ____ Is the Emergency Contact the Patient's Legal Gaurdian? Yes No

Employer Name: ____

Employment Status:
- ☐ Full Time
- ☐ Part Time
- ☐ Self Employed
- ☐ Retired
- ☐ Disabled
- ☐ Not Employed
- ☐ Active Military Duty
- ☐ Other / Unknown

Student Status:
- ☐ Full Time
- ☐ Part Time

GUARANTOR INFORMATION

Who is financially responsible for this account? SELF EMPLOYER SPOUSE FATHER MOTHER OTHER

Primary Insurance Company:	**Secondary Insurance Company:**
Subscriber Name:	Subscriber Name:
Subscriber Social Security Number:	Subscriber Social Security Number:
Subscriber Sex:	Subscriber Sex:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Home Phone #:	Subscriber Home Phone #:
Subscriber ID #:	Subscriber ID #:
Subscriber Group #:	Subscriber Group #:

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

I authorize the following people access to my protected health or medical information (list name(s) and relationship(s) to patient): ____

Do you have Advanced Directives? YES NO If yes choose type: __ Health Care Power of Attorney/Living Will __DNR

Preferred Pharmacy Name and Location: ____

Signature of Patient of Legal Guardian ____ Printed Name of Patient or Legal Guardian ____ Date ____ Time ____

MP VEERA MD PA

YOUR AUTHORIZATION TO COMMUNICATE FORM

As stated in the HIPAA privacy laws, this authorization form permits MP VEERA MD PA to use or disclose protected health information listed in the **Description Section** to the Entity or Person listed in the **Receiving Entity section** below for the following patient/you:

Name ______________________________ Birth Date ______________
Address ____
City/State/ Zip ____

Description of information to be given to Entity or Person.	Receiving Entity or Person Review & list if needed carefully
*Appointment or absentee from work information/form *Return to work or school information/form	Employer ______________ School ______________
*Family billing information *Financial information *Medical/List separately or mark as "ALL" ______________	Spouse (Provide full name) ______________ Other (Provide full name(s)) ______________
*Family billing information *Financial information *Medical/List separately or mark as "ALL" ______________	Parent(s) (Provide full name) ______________ ______________ ______________ ______________
*Portal Log in/updates via email *Texting	Your Email ______________ as updated by you Please provide updated cell number, if any______________
*Internet and social media (examples: google, facebook, instagram) viewing and communications/responses to you	Internet and social media ______________

Purpose

The purpose of this authorization is to meet your request for information disclosures and uses. ***(TURN PAGE TO COMPLETE FORM)***

***********TWO SIDED FORM→

Expiration date or event: This authorization shall be in force until revoked by the patient or _______________ date is the specific end date of this authorization.

Verification method or code: This practice will verify the identity of any entity or individual requesting protected health information by asking the your full name, date of birth and may request for the last four digits of your social security #

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to MP VEERA MD PA, 130 Perpetual Square Dr., Anderson, SC 29621 Attn: HIPAA Officer. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____Date _____________
Signature of Patient or Personal Representative (as defined by HIPAA)
Description of Personal Representative's Authority (attach necessary documentation)

____

****

Office Use Only (Employee please sign, scan and give back this original to patient):
Employee ___________________________Date received ______

☐ Copy given to patient by receiving employee

MP VEERA MD PA

CONTROLLED MEDICATION AGREEMENT

130 PERPETUAL SQ. ANDERSON, SC 29621
864.224.8689 FAX 864.222-1303

AS A GENERAL RULE WE _DO NOT_ WRITE CONTROLLED SUBSTANCES

The purpose of this agreement is to prevent misunderstandings about certain controlled substance medications, referred to as controlled medication, and to help both you and your provider comply with the state and federal laws regarding controlled medication. Because these medications have high potential for misuse, their administration is strictly controlled by local, state and federal governments. They include such classes of drugs as narcotics (for pain management, such as OXYCONTIN, HYDROCODONE, CODEINE, and STADOL), depressants (barbiturates), anti-anxiety medications (such as XANAX and ATIVAN), sedatives (such as AMBIEN) and stimulants (such as ADDERALL, ADIPEX-P and DIDREX). Their administration is intended to relieve, but not eliminate various symptoms, often pain; and is not simply to mask an underlying problem. Overdoses of controlled medications can cause serious illness or death.

Because your provider is prescribing a controlled medication for the management of your condition, you must agree to abide by the following guidelines. Please <u>initial beside each statement</u>. <u>Once read a full signature at bottom of page is required.</u>

_______ 1. I understand that I am responsible for my controlled medication. If the medication is lost, misplaced, or stolen, or if I do not follow the prescribed directions and I use all of the medication before I am eligible for a refill, I understand it will not be replaced.

_______ 2. I will not request or accept a controlled medication from any other physician or individual while I am receiving such medication from any of MP VEERA MD PA medical providers. Not only is it illegal to do so, but it may also endanger my health. The only exception is in the event that I am admitted to a hospital and a controlled medication is prescribed for me during my stay. (Please note that hospital admission does not include visits to an emergency department or an urgent care/minor care facility.)

_______ 3. Refills of my controlled medication:
   a. Will only be given during normal office hours. Refills will not be given at night, during office holidays or on weekends.
   b. Will not be given if I use all of the medication before I am eligible for a refill. I am responsible for taking my medication according to the prescribed directions, as well as for keeping track of the remaining amount.
   c. Will only be considered with at least seventy-two (72) hours advance notice. This holds true for requests submitted prior to the weekend.

_______ 4. I understand that if I violate any of the above conditions, my controlled medication prescription and/or treatment by MP VEERA MD PA providers may be terminated immediately. If the violation involves obtaining a controlled medication from another physician or individual, I may also be reported to the prescribing physician, corresponding medical facilities, and other necessary authorities.

_______ 5. I agree to abide by my physician's judgment regarding the necessity for controlled medication and the amount/frequency of medication that is best suited to the treatment plan as it is made, as well as when to cease the use of the medication.

_______ 6. I understand that if I am pregnant or become pregnant while taking controlled medication, my child could be physically dependent on the controlled medication and withdrawal can be life-threatening for the baby.

_______ 7. I understand that unannounced drug screens may be requested, and I will be in full cooperation with the administration of these tests.

_______ 8. I agree to fill all of my controlled substance prescriptions at the same pharmacy, and to provide my pharmacy information to MP VEERA MD PA. Any change of pharmacy will be promptly reported to the office.

_______ 9. I agree not to sell, lend or in any way give my controlled medication to any other person.

_______ 10. I understand that I will attend all required follow up visits with the physician to monitor the controlled medication and that failure to do so will result in discontinuation of this treatment.

_______ 11. I understand that there is a risk of addiction from controlled medications. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment facility.

_______________________________ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_______________________________ PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

_______________________________ SIGNATURE OF WITNESS

_______________________________ DATE

ISSUED 2/28/2012