

**We do not  
Accept Checks**

**Ravi Yalamanchili M.D, P.A.**

Yalamanchili Brain & Spine  
**141 Thomas Johnson Drive, Suite 200**  
Frederick, MD 21702  
Phone 301-846-0100 Fax 301-846-0244

**Please Print**

**Patient Registration / Information Sheet**

Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Sex: Female Male

First Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ SS Number: \_\_\_\_\_

City: \_\_\_\_\_ Home Number: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Number: \_\_\_\_\_

DOB: \_\_\_\_\_ Cell/Other number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Patient Employer \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address of Employer \_\_\_\_\_ Type or work \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Employer's Address \_\_\_\_\_ Type of work \_\_\_\_\_

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**Primary Insurance** \_\_\_\_\_ **Policy holder** \_\_\_\_\_

Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Policy holder's S.S. #** \_\_\_\_\_ **Policy holder's Birth date** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Policy holder** \_\_\_\_\_

Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Policy holder's S.S. #** \_\_\_\_\_ **Policy holder's Birth date** \_\_\_\_\_

**Third Insurance** \_\_\_\_\_ **Policy holder** \_\_\_\_\_

Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Policy holder's S.S. #** \_\_\_\_\_ **Policy holder's Birth date** \_\_\_\_\_

Nearest Relative **Not Living With You** \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

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.....  
Is this visit a **Workman's Compensation case?** (circle one) YES NO

If yes;

Date of accident \_\_\_\_\_ W/C Ins. Company \_\_\_\_\_

Where: \_\_\_\_\_ When \_\_\_\_\_

Did you file claim? YES NO Claim # \_\_\_\_\_

Is this visit due to an **Auto Accident?** (circle one) YES NO

If yes;

Date of accident \_\_\_\_\_ Auto Insurance \_\_\_\_\_

Where: \_\_\_\_\_ When \_\_\_\_\_

Did you file claim? YES NO Claim # \_\_\_\_\_

**Assignment of Benefits and Authorization to Release Medical Information**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Ravi Yalamanchili, M.D, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Ravi Yalamanchili, M.D, P.A. and its employees and agents, To release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

Signed (Insured Person) \_\_\_\_\_ Date \_\_\_\_\_

Responsible Person if Patient is a Minor \_\_\_\_\_

**Ravi Yalamanchili, M.D., P.A Office Policy Information Sheet**

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

**PLEASE NOTE:** All charges and/or fees are due at the time of service, when applicable. Please present your insurance card(s) and driver’s license to the office staff with this completed form. We will copy them for your records and return them to you immediately.

**MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ravi Yalamanchili, M.D, P.A for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If “other health insurance: is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

**FINANCIAL POLICY:** We are dedicated to providing you with the best possible care and services available. We regard your understanding of our financial policies as an essential element of your care treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless either you or your health care coverage carrier has made other arrangements in advance, full payment is due at the time of service

**YOUR INSURANCE:** We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. If your insurance requires a referral to a specialist, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current.** Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be “not covered” or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

**Minor Patients:** For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

**Cancellation:** We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a \$25 charge.

**RETURNED CHECKS:** It is our office policy to charge a fee of **\$35.00 for any returned checks.**

**COMPLETION OF FORMS:** We will be happy to complete attending physician’s statement, insurance and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms. **Please allow 10-14 business days for completion of forms.**

**DELINQUENT ACCOUNTS:** We reserve the right to add reasonable interest and collection charges to any account over 45 days past due. Interest of 1.5% would be added on (for each month) if the bill is not paid within 45 days.

**DECLARATION:** I have read and I understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

\_\_\_\_\_  
SIGNATURE & NAME of patient / insured / guarantor / responsible party

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE & NAME of Co-Responsible Party

\_\_\_\_\_  
DATE

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

I hereby give my consent for Ravi Yalamanchili, M.D, P.A to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (HCO). (The Notice of Privacy Practices provided by Ravi Yalamanchili, M.D, P.A described such uses and disclosures more completely). I too have the right to review the notice of Privacy Practices prior to signing this consent.

With this consent, Ravi Yalamanchili, M.D, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Ravi Yalamanchili, M.D, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that Ravi Yalamanchili, M.D, P.A. restrict how it uses or disclose to carry out HCO. 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 am consenting to allow Ravi Yalamanchili, M.D, P.A. to use and disclose my PHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ravi Yalamanchili, M.D. P.A may decline to provide treatment to me.

Signed by: \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Legal Guardian, if applicable  
Relationship to Patient

Date \_\_\_\_\_

**Ravi Yalamanchili, M.D, P.A.**  
**Yalamanchili Brain & Spine**

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referred By \_\_\_\_\_ Family Physician \_\_\_\_\_

Reason for visit today \_\_\_\_\_

Date of first episode of pain: \_\_\_\_\_

Date of injury or accident, (if Applicable): \_\_\_\_\_

Any back or neck trouble before injury? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe what caused the onset of your pain. \_\_\_\_\_

What makes your pain decrease? \_\_\_\_\_

What makes your pain increase? \_\_\_\_\_

Is the pain better, the same or worse than one month ago? \_\_\_\_\_

Does the pain increase with coughing or sneezing? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had:	YES	NO
Bowel control changes	_____	_____
Bladder control changes	_____	_____
Weakness of legs or feet	_____	_____
Numbness of legs or feet	_____	_____

Have you had:	YES	NO	Has it helped:	YES	NO
Bed rest	_____	_____		_____	_____
Traction	_____	_____		_____	_____
PT exercise	_____	_____		_____	_____
Chiropractic manipulation	_____	_____		_____	_____
Spine injection	_____	_____		_____	_____
Anti-inflammatory medication	_____	_____		_____	_____
Pain medications	_____	_____		_____	_____

Have you had:	YES	NO	WHEN
Spine x-rays	_____	_____	_____
CT scan	_____	_____	_____
MRI	_____	_____	_____
Bone scan	_____	_____	_____
EMG	_____	_____	_____
Myelogram	_____	_____	_____

Circle one: I am ..... right handed      left handed

**Current Medications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:**

\_\_\_\_\_

