Ravindra V Mailapur
Madison Surgical Associates, PC
207 Longwood Dr. SW
Huntsville, AL 35801
Tel: (256) 265-1890 / Fax: (256) 265-1891

PATIENT AGREEMENT AND ACKNOWLEDGEMENT

Name:		DOB:

☐ Yes ☐ No **FACILITY DIRECTORY:** While in our facility, if someone asks for you by name, may we acknowledge that you are here?

☐ Yes ☐ No **PATIENT'S RIGHTS:** I have been offered a copy of Madison Surgical Associates, PC Patient's Rights and Notice of Privacy Practices.

☐ Yes ☐ No **ASSIGNMENT OF INSURANCE RESPONSIBILITY**: I understand payment of all insurance benefits, basic and Major medical for this period of service must be made directly to Dr Ravindra V. Mailapur. If the check must be made out to me, I understand the check must be sent to this address: 207 Longwood Drive SW, Huntsville, AL 35801. If appeal efforts are necessary I authorize Madison Surgical Associates and his designee to appeal this claim on my behalf with my insurance company and/or my insurance company designee.

☐ Yes ☐ No **STATEMENT OF FINANCIAL RESPONSIBILITY**: I understand Madison Surgical Associates rendering services must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient or guardian. I understand that the fees paid for the initial interview is non-refundable. I understand that late fees, finance charges, administrative fees, statement fees, etc. will be assessed on all unpaid balances. I also understand that additional fees will be charged for credit card transactions. Patients who are considered a legal adult are financially responsible for all services rendered. I have been offered a copy of Madison Surgical Associates Patient Financial Responsibility statement.

☐ Yes ☐ No **PATIENT TREATMENT:** I understand that I may receive care or treatment from doctors who are not employees or agents of Madison Surgical Associates, but instead are independent practitioners. These independent doctors include, but may not be limited to, doctors who offer therapy (Psychiatrists / Psychologists), nurse practitioners and physician assistants.

☐ Yes ☐ No **CONSENT FOR MEDICAL/EMERGENCY TREATMENT AND COMMUNICATION**: I hereby consent to and authorize Dr. Ravindra V. Mailapur and his nurse practitioner or physician assistant to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary, and other general medical/emergency treatment considered advisable or necessary by the physician. I also give consent to Dr. Ravindra V. Mailapur and his employees to send me emails. Provider will use reasonable means to protect the security and confidentiality of Email information sent and received. However, Provider cannot guarantee the security and confidentiality of Email communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct.

I certify that all information given to Madison Surgical Associates on this contract is true and accurate. I have had the opportunity to ask questions that have been answered to my satisfaction. I have read this contract, understand its contents, and I have willingly signed this document.

X

Signature of Patient or legally Authorized Representative _____ Date _____ Witness / Employee Signature _____

Authorized Representative's Relationship to Patient _____ Name of Employee _____

I wish to submit my restrictions in writing to Madison Surgical Associates, PC and I understand that Madison Surgical Associates, PC may not agree with my restrictions.

X

Signature of Patient or legally Authorized Representative _____ Date _____ Witness _____

Signature Not Obtained

First Attempt: Date _____ Time _____ Reason: (check one) ☐ Emergency Situation ☐ Communication Barrier ☐ Other Reason: _____

Signature of Employee attempting to obtain signature _____ Witness _____

Second Attempt: Date _____ Time _____ Reason: (check one) ☐ Emergency Situation ☐ Communication Barrier ☐ Other Reason: _____

Signature of Employee attempting to obtain signature _____ Witness _____