Rupen Joshi, M.D., L.L.C.
333 Whitesport Drive, Suite 305
Huntsville, Alabama 35801
Phone: (256) 880-1222 Fax: (256) 880-2666

Today's Date _____ Birthdate: _____ SS#: _____

Physician Referred by: _____

PERSONAL INFORMATION

Patient's Name: _____ M F

Name you wish to be called: _____ Marital Status: M D S W

Street Address: _____

City: _____ ST: _____ Zip: _____

Employer/School _____

Employer/Occupation: _____

TELEPHONE

Home Phone # _____

Work Phone # _____

Mobile Phone # _____

Can we leave a message on your answering machine? ❑ Yes ❑ No

Can we email you? ❑ No ❑ Yes Email address: _____

SPOUSE

Spouse's Name _____ Phone No. _____

Spouse's Employer _____

RELEASE INFORMATION

I authorize release of information (including facsimile transmission) relative to my medical record and/or lab results to: ❑ Myself Only ❑ My Spouse ❑ My Child ❑ Legal Ward _____ ❑ Other _____

FOR OFFICE USE

I revoke the above authorization because _____

_____ Date _____ *Initials* _____

EMERGENCY

In the event of an emergency please contact:

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____

INSURANCE INFORMATION

Primary Insurance *(Please provide insurance card for us to copy)*

Plan Name _____ ID# _____ Group # _____

Deductible: $_____ Co-Pay: $_____

Name of insured: _____

Relationship to patient: _____

Insured's birthday: _____ Insured's SSN: _____

Secondary Insurance *(Please provide insurance card for us to copy)*

Plan Name _____ ID# _____ Group # _____

Deductible: $_____ Co-Pay: $_____

Name of insured: _____

Relationship to patient: _____

Insured's birthday: _____ Insured's SSN: _____

Please turn over the page and complete the back side > > >

PERSON TO BILL *Who will pay for services not covered by insurance?*

Name: _____

Relationship to Patient: _____ DOB: _____

Street Address: _____ SSN: _____

City: _____ ST: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Note: We accept personal checks and/or cash. Patient balances over 30 days old are subject to a 1 ½% monthly service charge. (18% annually)

I have read and understand the practice policies regarding patient expectations.

X _____
Signature Date

AUTHORIZATION AND RELEASE

I hereby authorize Rupen Joshi, M.D., L.L.C. to release any information regarding service rendered to me or my child (including diagnosis, record of treatment or examination) to third party payers in consideration of payment for my care or to other healthcare practitioners involved in providing my/my child's care. I authorize and request my insurance company/Medicare/Medicaid to pay benefits otherwise payable to me directly to the physician/physician group. I understand that my insurance carrier/Medicare/Medicaid/benefit provider may pay less than the actual bill for the services; and I agree that I am responsible for payment of all services rendered regardless of insurance coverage. Should this account be turned over to collections, I am responsible for all costs of collections as well as attorney fees.

Signature of patient (or parent if minor): _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how you access your information. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date

FOR OFFICE USE

☐ Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

_____ _____ _____ _____
Employee Signature Date Witness Signature Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

Due to Federal Law changes we need additional information on our patients now. Please fill out the following information.

What Pharmacy do you use? Pharmacy Name: _____

Street: _____

Preferred Language: _____

Race (Select One)

___ White

___ Asian

___ Hawaiian/ Pacific Islander

___ Unknown

___ Black or African American

___ American Indian/ Alaska Native

Other Race: _____

Ethnicity (Select One)

___ Hispanic or Latino

___ Non-Hispanic or Non-Latino

___ Unknown

Best way to reach you:

Home #: _____

Work #: _____

Cell #: _____

We also are now able to web enable you to our computer system, this is where you can see your lab results, message the nurse for refills, ask any questions that you have, and appointment reminders are sent to your email accounts.

Email: _____

Would you like for us to set you up for this system? _____Yes _____No

If you checked Yes on the web enable Please make sure we have the correct Email for you!

Thank you!

Rupen Joshi, M.D., L.L.C.
333 Whitesport Drive, Suite 305
Huntsville, Alabama 35801
Phone: (256) 880-1222 Fax: (256) 880-2666

MEDICAL / FAMILY / SOCIAL HISTORY

Name: _____ Date: _____

SS#: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today?

_____

_____

_____

Current problem is the result of

❑ Illness ❑ Work Accident ❑ Car Accident ❑ Injury ❑ Other _____

When did you first notice the symptoms _____

Past Medical History

Surgeries / Hospitalization	Year	Complications

Medical Problems:

Please list all medical problems / illnesses for which you are currently being treated:

_____

_____

Medications	Dose	How Long?	Side Effects

Allergies: Medications: _____

Food / Environmental: _____

Other: _____

Name: _____

Ss#: _____

MEDICAL / FAMILY / SOCIAL HISTORY

Review of Systems

Are you currently having or have you had problems with: (if yes, please describe)

Eyes	❑ No	❑ Yes	_____
Ears, Nose, Throat	❑ No	❑ Yes	_____
Respiratory (Lung/Breathing)	❑ No	❑ Yes	_____
Gastrointestinal	❑ No	❑ Yes	_____
Cardiovascular (Heart)	❑ No	❑ Yes	_____
Urological Problems (Bladder)	❑ No	❑ Yes	_____
Diabetes	❑ No	❑ Yes	_____
High Blood Pressure	❑ No	❑ Yes	_____
Endocrine (Thyroid)	❑ No	❑ Yes	_____
Hematologic (Bleeding)	❑ No	❑ Yes	_____
Numbness / Tingling	❑ No	❑ Yes	_____
Psychological Problems	❑ No	❑ Yes	_____
Neurological Problems	❑ No	❑ Yes	_____
Psychiatric Problems	❑ No	❑ Yes	_____
Allergic / Immunologic	❑ No	❑ Yes	_____
Musculoskeletal	❑ No	❑ Yes	_____
Integumentary (Skin)	❑ No	❑ Yes	_____

Family History

Has any one in your immediate family been diagnosed with the following disease (if yes, please indicate family member)

Cancer	❑ No	❑ Yes	_____
Heart Disease	❑ No	❑ Yes	_____
High Blood Pressure	❑ No	❑ Yes	_____
Diabetes	❑ No	❑ Yes	_____
Bleeding Disorders	❑ No	❑ Yes	_____
Other (specify):			_____

Social History

Please check:

❑ Employed (occupation) _____
❑ Work in the home
❑ Student
❑ Single ❑ Married ❑ Separated ❑ Widowed
❑ Children ❑ Yes ❑ No Ages _____

Exercise: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never
What type of exercise: _____

Are you on a special diet?	❑ No	❑ Yes	Describe: _____
History of substance abuse?	❑ No	❑ Yes	What: _____
Smoke currently?	❑ No	❑ Yes	Packs per day _____ for _____ years.
Previously smoked?	❑ No	❑ Yes	
Drink Alcohol?	❑ No	❑ Yes	Frequency _____ Type _____

Reviewd by: _____ _____ MD **Date:** _____

Rupen Joshi, M.D., L.L.C.

Patient Health Questionnaire

Patient Name:_____ DOB:_____ Date:_____

General/Constitutional

Weight loss	O Yes	O No
Weight gain	O Yes	O No
Loss of appetite	O Yes	O No

ENT

Nose bleeds	O Yes	O No
Ringing in ears	O Yes	O No
Hearing loss	O Yes	O No
Sore throat	O Yes	O No
Eye pain	O Yes	O No
Blurred vision	O Yes	O No

Cardiovascular

Shortness of breath	O Yes	O No
Chronic cough	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No

Gastrointestinal

Nausea	O Yes	O No
Vomiting	O Yes	O No
Abdominal pain	O Yes	O No
Change in bowel habits	O Yes	O No

Hematology

Anemia	O Yes	O No
Easy bleeding	O Yes	O No

Genitourinary

Urinary incontinence	O Yes	O No
Urinary urgency	O Yes	O No
Urinary frequency	O Yes	O No

Musculoskeletal

Joint pain	O Yes	O No
Joint stiffness	O Yes	O No
Joint swelling	O Yes	O No

Endocrine

Excessive thirst	O Yes	O No
Excessive sweating	O Yes	O No

Neurologic

Headache	O Yes	O No
Tingling/numbness	O Yes	O No
Memory loss	O Yes	O No
Confusion	O Yes	O No

Psychiatric

Depression	O Yes	O No
Anxiety	O Yes	O No

Surgical History

O None	O Cataract	O Heart Stent	O Pacemaker, cardiac
O Tubal Ligation	O Hysterectomy	O Mastectomy	O Appendectomy
O Prostatectomy	O Thyroidectomy	O Gallbladder	O Knee replacement
O Back surgery	O Hip surgery		

Rupen Joshi, M.D., L.L.C.

Patient Health Questionnaire

Past Medical History

O None O Arthritis O Diabetes O Cancer O High Cholesterol
O COPD O Stroke O Hypertension O Atrial Fibrillation O CHF
O Coronary Artery Disease O Kidney Disease

Family History- Please mark None or mark those that apply to you:

Mother: O None O Diabetes O High Cholesterol O Heart disease O Heart attack
O PVD O Hypertension O Cancer O Stroke

Father: O None O Diabetes O High Cholesterol O Heart disease O Heart attack
O PVD O Hypertension O Cancer O Stroke

Grandparents: O None O Diabetes O High Cholesterol O Stroke O PVD
O Heart disease O Heart attack O Hypertension O Cancer

Social History- Please mark the answers that apply to you:

Marital Status: O Married O Single O Divorced O Widowed

Occupation: O Full-time O Part-time O Retired O Unemployed O Disabled

Exercise: O Never O Daily O 1-2 x weekly O 3-4 x weekly

Caffeine: O None O Daily O Occasionally
If yes: O 1 cup/drink daily O 2-3 cups/drinks daily O 4 or more cups/drinks daily

Smoking: O Yes O No O Trying to quit O Previous smoker
If yes, cigarette daily uses: O ½ pack O 1 pack O 2 packs O More than 2 packs

Alcohol: O Never O Daily O Social Drinker O Trying to Quit
O Recovering Alcoholic

Updated Office Policies for Dr. Joshi- 2024

1. **Prescription refills must be phoned into our automated** voicemail. Please leave a detailed message with your name, the name of medicine and name of pharmacy and medicine dosage. Please give 48-72 hours for refill or you can get **webenabled** at front office and be able to send the refill request directly to Dr. Joshi online!

2. **No Show Fees will be assessed for every missed appointment.** We can no longer write off no show fees, **so please call us if you cannot make it to your appointment**. We will give you a courtesy call with the phone number we have on file to remind you the day before but we are not responsible if you do not receive the message.

3. **Televisit copays/balances will be collected before your appointment time upfront.** Televisits are the same as office visits per the insurance companies and so the **copay/balance** will be collected by our staff before your appointment.

4. **New insurance cards must be emailed to our office or brought in before your visit. Please email them to drjoshi35801@gmail.com.** We need to verify all new insurance and this takes time, so please call/email us with the new insurance information ASAP.

5. **Please treat all employees with respect and consideration.** They are trying their best to help you so please be courteous to them so we can quickly help you resolve any issue you are facing.

_____ _____

Patient Signature Date

Rupen Joshi, M.D., L.L.C.

333 Whitesport Dr. Ste 305
Huntsville, AL 35801
Phone: 256-880-1222 Fax: 256-880-2666

Authorization for release of Medical Information

Release To:

Rupen Joshi, M.D.
333 Whitesport Dr. Suite 305
Huntsville, AL 35801

Release From: (Whom do we need to get your records from?)

Doctor Name: _____ Phone #: _____

Doctor Name: _____ Phone #: _____

Doctor Name: _____ Phone #: _____

Please list previous doctors that you have seen for us to get records from. Thanks

I hereby authorize the release of my medical records, including but not limited to medical history, physical conditions, x-rays, lab studies, and/or treatment of the psychiatric and substance abuse records to the above name and address. Photo static copies of this authorization carry the same authority as the original.

Patient's Full Name (Print): _____

Date of Birth: _____ Social Security #: _____

_____ Date: _____

Patient or Legal Guardian Signature

Medicare Shared Savings Program
Accountable Care Organizations

Working together to give you the best care.

Rupin Joshi MD

is part of an Accountable Care Organization (ACO). We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

We provide coordinated care for you to get well & stay well

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

You may have access to expanded benefits

- We may offer telehealth services which let your primary care doctor care for you without an in person visit, no matter where you live.
- Ask your health care provider if you qualify for these benefits.

Get the most from your care with our communication & support

- **Ask about signing up for our secure online portal.** You'll get 24-hour access to your personal health information, including lab results and communication from your health care provider.
- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit **Medicare.gov** and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

Ask our front desk, or call us at 256-880-1222. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227).
Learn more about Accountable Care Organizations here:

Print: _____

Sign: _____

Date: _____

CMS MEDICARE SHARED SAVINGS PROGRAM

Dr. Rupen Joshi, MD

333 Whitesport Dr. #305
Huntsville, AL 35801
Phone. (256) 880-1222 Fax: (256) 880-2666
DrJoshi35801@gmail.com

Date_____

I have discussed advanced care planning with Dr.Joshi and received a copy of the Advanced Directive.

Print_____

Sign_____