**PRAFULLA K. KONERU, M.D., S.C.**
**5 EXECUTIVE COURT, SUTIE 1**
**SOUTH BARRINGTON, IL 60010**

**Ph: 847-382-8200**
**Fax: 847-382-8210**
**www.prafullakkonerumd.com**

PLEASE PRINT CLEARLY Account # ____________________

**PATIENT INFORMATION:** **Language Spoken at home: ____________________________**

First Name: ________________________________ Middle Initial: ____ Last Name: ___________________________

Age: _______ Date of Birth: _______________________________ Social Security #:___________________________

Address: _____________________________________________________________ Apt/Unit: __________________

City: _______________________________ State: ____ Zip: ____________**Status**: Single Married Divorced Widowed

Home ph: ______________________________ Work: _____________________ Cell: __________________________

**EMAIL: ________________________________________________________________**

Do we have your permission to email you regarding normal results/appointment reminders? ___ YES ___NO

Employed by: __________________________________________________ Occupation: _______________________

**Pharmacy Name**: __________________________________________ **Phone**: ________________________________

**SPOUSE (*or partner)* INFORMATION:**

First Name: ________________________________ Middle Initial: ___ Last Name: ____________________________

Date of Birth: ____________________________________ Social Security #:___________________________________

Employer: ______________________________ Occupation: ______________ ______ Cell: _____________________

Emergency Contact: __________________________________________________________________________________

Relationship: __________________________________ Phone #: __________________________________________

Referred by: _________________________________________________________________________________________

Primary Care Physician: ___________________________________________ Phone: __________________________

**INSURANCE INFORMATION:**

Policyholder: ________________________________________________________________________________________

Insurance Company: ___________________________________________________________________________________

ID#: ________________________________________________________ Group #: ___________________________

Provider Phone # OR Customer Service #: _____________________________________________________________

Secondary Insurance: ________________________ ID: ______________________________ Group #:____________

I hereby authorize PRAFULLA K KONERU, M.D., S.C. to release to my insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical Care. I also authorize my insurance company to pay directly to the above named practice the amount due in any pending claim for Basic Medical, Major Medical and/or surgical treatment or services, by reason of such treatment or services rendered to me.

**SIGNED: ____________________________________________________________ DATE: ________________________**

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DATE: ______________________________________

PATIENT: __________________________________________________

It is the policy of our office to call you with **Abnormal** Laboratory Results, Pap Smears, Ultrasound and X-ray Reports. If you have not heard from us in 21 days of having the testing completed, please call our office.

Whom may we notify of abnormal test results?

Patient Only ____ Spouse____ Other ___________________________

DO WE HAVE PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICEMAIL? YES NO

BEST NUMBER TO LEAVE MESSAGES: (_______) _________-___________

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN THE ABOVE.

ADVANCED DIRECTIVE: ____________________________________________

PATIENT SIGNATURE: _____________________________________________

==============================================================================

**Office Policy Effective 4/1/17**

There will be a $25 charge for any No-Call No-Show appointments. Please be sure to give a 24hrs notice if you’re unable to make your appointment.

PATIENT INITIALS _______________

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Routine HPV Testing Consent Form

Patient Name: ________________________________________ Date of Birth: _____________

- Recent medical advances have shown most cervical cancer is caused by HPV (Human Papilloma Virus)
- The PAP smear has always tested for cervical cancer, but it is not perfect and can miss the disease up to 50% of the time
- Testing for HPV virus has a higher sensitivity in determining the risk for cervical cancer.
- HPV testing is recommended by many health organizations including the American Cancer Society (ACS), National Institute for Health (NIH) and the American College of Obstetricians and Gynecologists (ACOG.) Our office now recommends this testing procedure as well.
- HPV testing should be done on women between the ages of 30-64 years of age along with their annual PAP smear (called co-testing)
- HPV is a very common virus, almost like a cold. Any woman that has had ANY sexual contact (not just intercourse) may acquire the virus
  - Many women get HPV but the immune system will suppress the virus
  - If you test positive for HPV, your body is not able to fight off the virus
  - If you test positive for HPV, your doctor will need to follow you more closely
- Insurance Company payments:
  - Most insurance companies will pay for the HPV testing, **however; our office cannot guarantee payment of any type.**
  - You should contact your insurance company for verification; the CPT (procedure) code is 87624 and the ICD-10 diagnosis code would be Z01.419.
  - If you have not met your deductible or your co-insurance amount, you will be responsible to pay for the testing.
- **We will perform this test on everyone between the ages of 30-64**, unless you specifically request not to be tested with the most sensitive tests available for cervical cancer.
- **If your pap smear shows an abnormal result called "Atypical Squamous Cell of undetermined Significance, the lab will automatically do the HPV testing to determine whether you are at high risk and require additional office procedures called colposcopy & biopsy.**

I have had the opportunity to discuss this with my provider and all of my questions regarding co-testing with PAP smear and a HPV test have been answered. I am aware if my insurance company does not pay for the HPV test, then I am fully responsible.
__________ I choose not to get co-testing with the HPV test at this time even though my doctor recommends it. I choose to get only the PAP smear.

PATIENT SIGNATURE ___________________________________________ DATE____________

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## Informed Voluntary Consent for HIV Test

I have voluntarily agreed to take a blood test in order to determine whether I have been infected with the human immunodeficiency virus (HIV) or any other identified causative agent of acquired immunodeficiency syndrome (AIDS.)

**EXPLANATION OF THE TEST**

I understand the test is performed by withdrawing a sample of my blood and conducting laboratory tests and that the purposes of the test are to determine whether I have been infected with HIV and to help my physician decide what kind of medical treatment I need. Further, if my test results are positive, the result will be reported to the Illinois Department of Public Health. I know to take steps to protect other persons from my infections, and I will be able to make decisions about my future health care and other personal matters.

I understand that an HIV test results may not be clear. I understand that a positive test result means that I probably have HIV infection and that I should consider myself able to infect other people. However, very rarely, the test can be wrong and make it appear that I am infected when I am not. I understand that if the test results are positive I will provide referrals for further information of counseling for follow up care and for precautions against transmitting the infection. I also understand that being HIV positive does not mean that I have AIDS. I understand that my doctor must look at a number of factors to determine if I have AIDS and that there is no single 100% accurate test that can show if I have AIDS.

I understand that a “negative” test result means that I probably do not have an HIV infection. However, I understand that if I have been recently infected with the HIV virus it may take an indeterminate period of time before my blood becomes HIV positive and during that time I can infect other people. Therefore, if my test results are negative I may need to be testes in the future to confirm that I have not been infected.

**EXPLANATION OF PROCEDURES TO BE FOLLOWED**

I understand that all reasonable efforts to provide confidentially to the extent provided by law will be made and the results will not be disclosed to unauthorized third parties without my express written authorization. I understand my physician or health care facility where the test was done can disclose my identity and the results of the test to certain legally authorized persons or entities, such as an authorized agent or employee who provided patient care or handles or processes specimens of body fluid or tissue and who has a need to know such information.

I understand that upon my request and when permitted by law I have the right to provide written informed consent by using a coded system that does not link my identity with the consent to be tested or the result of the test. I further understand that I have the right to withdraw my consent to the testing process at any time.

I specially request that the result of this test by communicated to the following physicians, other health care providers and health facilities involved in my medical care.

With the information provided above being clear to me and having been afforded the opportunity to have asked questions and have all of my questions answered. I hereby warrant that I freely give my informed consent to test my blood for HIV infection.

X_________________________________ _______________________________ _______________

Signature of test subject or legally authorized Physician’s signature Physician’s Date

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## PERSONAL HISTORY

NAME: ___________________________________________________ DATE OF BIRTH: ________________

RELIGION: _______________________________EDUCATION:____________________

ETHNIC ORIGIN
ASIAN
CAUCASIAN
AFRICAN AMERICAN
EASTERN EUROPEAN

Are you here for a routine check-up? YES / NO

Do you have any medical problems at this time? YES / NO

## GYNECOLOGICAL & OBTETRICAL HISTORY

Date of last menstrual period ____________________________ was it normal? YES / NO

What birth control are you using now? NONE / IUD / DIAPHRAGM / TUBAL LIGATION / OTHER__

Age first period began ________ # of day between _______________ Days of menstrual flow ________

# of pads/tampons per day used at the beginning of period ___________________End________________

Are you periods irregular? YES / NO
Pain with or prior to periods? YES / NO
Clots with Periods? YES / NO
Any bleeding between periods? YES / NO
Any bleeding during or after sex? YES/NO
Any pain with sex? YES/NO
Medication for pain with periods? YES/NO
Any abnormal vaginal discharge? YES/NO
Have you ever had a venereal disease YES/NO
Have you had the German Measles? YES/NO

Have you ever had a pelvic infection? YES /NO
Have you passed the "change of life?" YES / NO
If yes:
Have you had any bleeding? YES/NO
Any hot flashes? YES/NO
Do you take hormones? YES/NO
Have you noticed any lumps or discharge from your breasts or nipples? YES/NO
Do you lose urine when you cough or sneeze? YES/NO

How many total Pregnancies? _______________ How many living children?_________________________

How many miscarriages or abortions? __________________ Any premature babies?__________________

Date of last pap smear: ________________________

PREGNANCIES: (list in order)

| Date: | Sex: | Weight: | Complications: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Age at first sexual intercourse ______________________

## ALLERGIES & SENSITIVITIES: (Allergic to)

(Specify please)

a. Morphine, Codeine, Demerol NO YES ___________________________________
b. Novocaine or other Anesthethics NO YES ___________________________________
c. Aspirin or other pain medication NO YES ___________________________________
d. Tetanus or other serum NO YES ___________________________________
e. Adhesive tape, Iodine, Foods NO YES ___________________________________
f. Penicillin, Tetracycline NO YES ___________________________________
g. Sulfa Drugs, other Antibiotics NO YES ___________________________________
h. Any other Drug or Medication NO YES ___________________________________

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**DRUGS RECENTLY TAKEN**

Within the past 6 months have you taken any of the following? If so, when and what amount, if known.

a. Cortisone, ACTH NO YES______________________________________
b. Anticoagulants (Blood thinners) NO YES ______________________________________
c. Tranquilizers (tension Relievers) NO YES ______________________________________
d. Hypertensive's (high Blood Pressure Medicine NO YES ______________________________
e. Any other drugs NO YES __________________________________

**PAST HISTORY**

Have you ever had any operations such as tonsillectomy, etc? List when, what type of operation, and where…
_______________________________________________________________________________________________

**MEDICAL HISTORY**

High Blood Pressure, Asthma, Hepatitis, etc. ___________________________________________________________
_______________________________________________________________________________________________
Hospitalizations? ______________________________________________________________________________
Serious Injuries? ______________________________________________________________________________
Transfusions? ____________________________________________When?_______________________________

**SKIN:**
Have prolonged bleeding from cuts? YES NO
Ever had blood clots in legs? YES NO

**EYES:**
Wear glasses or contact lenses YES NO

**EARS**
Difficulty in hearing? YES NO
Ringing in ears? YES NO
Frequent dizzy spells? YES NO

**NOSE, MOUTH, THROAT**
Frequent nose bleeds? YES NO
Wear dentures? YES NO
Frequent sore throats? YES NO
Hay fever or allergies? YES NO

**CHEST**
Ever had high blood pressure? YES NO
Heart trouble or murmur? YES NO
Chronic Cough? YES NO
Ever cough up blood? YES NO
Ankle swelling? YES NO
Heart often skip a beat or race? YES NO
Heart pain? YES NO

**GASTROINTESTINAL:**
Chronic constipation or diarrhea? YES NO
Recent change in bowel habits? YES NO
Blood or tarry stools? YES NO
Gallbladder disease, ulcer, jaundice colitis YES NO

**URINARY TRACT-**
Ever had a kidney or bladder infections YES NO
Now have pain, urgency or burning with urination? YES NO
Ever passed blood in urine? YES NO

**NEUROMUSCULAR-**
Ever had a convulsion? YES NO
Ever has swollen red or still joints? YES NO
Have paralysis or deformity? YES NO

**ENDOCRINE-**
Any thyroid trouble? YES NO
Ever been told you're diabetic? YES NO
Has your weight varied over 10 lbs in the past year? YES NO

**FAMILY HISTORY:**
Cancer: ___________________________________
Diabetes: __________________________________
Heart disease: ______________________________
Hypertension: ______________________________
Other: _____________________________________

**SOCIAL HISTORY:**

Marital status: __________________If married, how long? _____________If divorced, how long? _____________
If married, is your marriage satisfactory? YES NO
Are you usually depressed lately? YES NO
Any special problems worrying you? YES NO
Do you smoke? YES NO
How much?_____________________________

Do you drink? YES NO
How much? _________________________________________
Are you presently taking recreational drugs, marijuana, cocaine, etc YES NO If so, what? ________________________

_____________________________________________ ____________________________________________
Signature of person completing this form relationship to patient (or self)

________________________________________________ ____________________________
Patient's name ( PLEASE PRINT) DATE

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# Prafulla Koneru, M.D. Financial Agreement and Consent 2017

Your Signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

**Update your Contact Information:** We depend on accurate information to contact you regarding prescriptions, lab results and billing. If you move or change your e-mail or telephone number please inform the front desk so we can update our database.

**Billing your Insurance:**
- Please present your current health insurance card at each office visit. If you present an incorrect card, please contact us immediately to update your information.
- If you have **no insurance** then payment in full is required at the time of service.
- Our office will bill validated primary and secondary insurance. If you have a secondary, please clearly indicate which insurance is primary and which is secondary. Any remaining balance will be billed to you.
- **Know your insurance.** If you have a deductible or coinsurance you will likely have a balance for which you are responsible. If your insurance plan has exclusions, you will owe a balance. Please check with your insurance company to determine your benefits and the portion you may owe.
-

**Payment for Service**
- Co-pays, co-insurances and deductibles must be paid at the time of service. **If your co-pay is not made within 24hours of the time of service, there will be an additional $15.00 fee. ________ please initial.**
- **We require a valid credit card be kept on file to cover any past due balance. Please see back of this sheet.**
- We accept cash, checks, money orders, Visa, MasterCard and debit cards. Credit cards and debit cards payments may be made in person or by phone.
-

**Returned Checks:** The charge for a non-sufficient funds (NSF) check is $25. You must pay in full for the NSF check and NSF fee within 10 days of notice. If payment is not received by the due date, we will forward the returned check to the District Attorney's office. It is a felony to knowingly write a bad check. For the next 36 months, cash or equivalent payment at the time of service is required.

**Collections/past Due Accounts:** When your account remains unpaid after 90 days we maintain the right to refer the account to an outside collection agency. If your account is sent to a collection agency you may be asked to find another provider.

**No Shows and Cancellations:** Please be considerate.
We require a **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24hours of the appointment time, a 2 hour notice is required. Failure to give proper notice for cancellation or reschedule will re sults in:
- A $25 charge for missed appointments or late cancellations
- Potential dismissal from our practice for a third missed appointment

**Copies of Medical Records and Other Forms:** Records requests are generally fulfilled within 5 days. When the request is addressed at the time of service, we can generally provide the records immediately. There is a copy fee for medical records. If you would like us to fax the records to another healthcare provider, there is no charge for this service.

*I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay Prafulla K. Koneru, M.D. directly. A copy of this authorization can be considered an original for insurance purposes.
* I hereby consent to and authorize the performance of all examinations, treatments and medical services by Prafulla K. Koneru, M.D. and her staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlines in this document.

_____________________________________________ ________________
Signature of Patient or Parent Guardian (if patient is under 18) Date

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## Prafulla Koneru, M.D. Credit Card on File Policy

**Your Signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.**

As of May 2017, we require a valid credit card be kept on file.

This policy is designed to:

- Help you avoid all billing related fees and hassles
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts

**Your signature will authorize the card to be sued only when your balance becomes past due.**
**How the policy works:**

1. At the time of registration or check-in, you will be asked for your credit card information. That information will be held securely and will only be used if you have a **past due balance.**
2. As always, we will bill your insurance carrier first for all charges related to the visit. If you have a secondary insurance, you must provide both primary and secondary insurance information at the time of the visit and clearly indicate which is primary.
3. When we receive an explanation of benefits (EOB) from your insurance we will send you a statement to the address you provide. If we have not received payment by the end of that same month, we will charge the credit card on file for the balance due (on that statement)
4. You are responsible to update our office if your address changes. If your mail is returned, your credit card will be billed on the date on the statement we mailed.
5. If we attempt to use your card and it is declined or has expired, we will contact you by telephone, and you will be responsible for updating our records.
6. If your balance exceeds $100, we will contact you first to set up a payment plan; however, if we are unable to reach you within 3 business days and/or you do not respond to your messages, we will automatically set you up for a $100 per month payment plan until your balance is paid in full. Your card will automatically be run each month.

**Again, your credit card will only be charged when your balance becomes past due.**

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, please contact our office so we may correct any errors or resolve any concerns. If a mistake had been made, we will reverse the charges. In the event of duplicate payments, we will issue a refund. We will make every effort to resolve any billing issues with your insurance company before you are billed or charged. This credit card policy is not intended to reduce or eliminate your ability to appel unpaid claims with your insurance company but rather to quickly and effectively handle past due balances after every effort has been made to receive payment from your insurance company.

I have reviewed a copy of Prafulla Koneru, M.D.'s billing policy and agree to provide my credit card information for the sole purpose of payment for medical care provided.

______________________________________________ ____________________
Signature of Authorized User — Date

_________________________________________ _______________________________________
Name as it appears on your Credit Card — Credit Card Number

Visa or MasterCard only

____________________________ __________________
Expiration Date — CVV Code

**If you do not agree please read the statement below and initial.**

I will pay **FULL** balance once I receive statement. ______________ Initials

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**NOTICE OF PRIVACY PRACTICES**

## PATIENT ACKNOWLEDGEMENT FORM

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal Law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment and health care operations, you must acknowledge that you have received a copy of our Notice of Privacy Practices informing you how our office may use and disclose your Protect Health Information.

You should carefully read out Notice of Privacy to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal Law gives you certain rights regarding the use and disclosure of your Protected Health Information. Their rights include:

1. The right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment or health care operations.
2. The right to receive confidential communications of your Protected Health Information, if applicable
3. The right to inspect and copy your Protected Health Information
4. The right to receive an accounting of the disclosures of your Protected Health Information.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

Print Name of Patient: ____________________________________________________________

Signature: ______________________________________________________________________

Date: ______________________________________