Uthaiah Kokkalera, MD
Advanced Minimally Invasive Surgery, Robotic Surgery, Trauma and Acute Care Surgery
18250 Roscoe Blvd #335, Northridge, CA 91325 ● Ph 818-700-7900 ● Fax 818-700-7901●info@miroboticsurgery.com

CONFIDENTIAL

Date _____

Personal Information

Name: _____ **Age**: _____ **Date of Birth**: _____
(Last) (First) (MI) (mm/dd/yyyy)

Address: _____
(Street) (City) (State / Zip)

Phone: _____ _____
(Home) (Cell)

Email: _____ ☐ Ok to contact via email?

Employer: _____

Address: _____

Social Security No: _____-_____-_____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____
(Street) (City) (State / Zip)

Phone: _____

Referral Source:

Name: _____

Address: _____
(Street) (City) (State / Zip)

Primary Care Physician

Name: _____

Phone: _____

Address: _____
(Street) (City) (State / Zip)

Signature: _____

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Date _____

Reason for visit: _____

Duration of symptoms and any additional symptoms: _____
_____
_____
_____

Any history of:

☐ High Blood Pressure ☐ Diabetes ☐ Heart Attack
☐ Stroke ☐ Breathing difficulty ☐ Abnormal Heart Rhythm
☐ Kidney Problems ☐ Blood Clots ☐ Bleeding Problems
☐ Other problems:

Past Surgeries if any: (Approximate)

☐ _____ Date: _____
☐ _____ Date: _____
☐ _____ Date: _____

Medications: _____
_____
_____
_____

Medication Allergies: _____

Smoking : ☐ Yes ☐ No **Alcohol :** ☐ Yes ☐ No ☐ Social **Drugs :** ☐ Yes ☐ No

Family history of:

☐ Heart Disease ☐ High Blood Pressure
☐ Cancer If yes: Type of cancer: _____

☐ Married ☐ Single ☐ Divorced ☐ Children _____

Type of Work: _____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge
(Name of the Patient)

that I have received a copy Uthaiah Kokkalera M.D. Inc.'s Notice of Privacy practices. This notice describes how Dr. Uthaiah Kokkalera may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of the patient (or Authorized Representative)

_____

Print Name: _____

Relationship to patient: _____

Date: _____

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Patients with Insurance
As a courtesy to patients with private healthcare insurance, we do complete and file claims with the appropriate insurance companies. However, all patients are kindly requested to understand that the overall financial responsibility for our services still remains the patients themselves and not their insurance companies. Even though an insurance claim if filed on the patients behalf, this office can not accept responsibility for collecting the claim, nor can it get involved in negotiating settlement on a disputed claim.

Patients with Medicare
It is the policy of this office to "accept assignment" on all claims submitted to Medicare on behalf of our patients. This means that we will file a claim with Medicare on the patients' behalf and look for payments directly from Medicare for 80% of the allowed fees and then bill the secondary insurance. Those without secondary insurance, or if no further payment is allowed by the secondary insurance, patients will be billed for any balance allowed by Medicare. This amount is due and payable by the patients immediately upon receipt of our statement.

Consent for treatment
I hereby consent to examination and treatment deemed advisable by Dr Uthaiah P Kokkalera and his professional staff. I understand that I shall be responsible for any service with is not covered in part of as a whole by the insurance.

Financial Responsibility
I, the undersigned, do hereby assume full responsibility for the payment of services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services rendered to Uthaiah Kokkalera, M.D. I understand that I shall be responsible for any service that is not covered by insurance.

Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent amounts shall bear interest at a legal rate.

The undersigned certifies that he/she has read the foregoing and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept these terms.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize insurance and/or Medicare payments for services rendered to me or my dependents to be paid to Uthaiah Kokkalera, M.D.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of medical information necessary to process all claims to my insurance carrier.

Signature of Patient (or authorized representative): _____

Print Name: _____ Relationship: _____

Date: _____