Maya Family Clinic Patient Registration

Dr. Chirag Patel, D.O. ***3530 W 159th St*** ***Markham, IL 60428***

Personal: Female/Male

Patient Name(print) : _____

Date of Birth: _____

Street:

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

***Emergency* Contact Name and Phone Number (MUST PROVIDE):**

_____

TREATMENT AND PAYMENT AGREEMENT

I authorize examinations and treatments for this and all following Physician visits. I authorize payment and assignment of Insurance benefits to Healing Wounds Ltd dba Maya Family Clinic (Dr. Patel's office). I understand that I am personally responsible for ALL charges and Deductibles. I am personally responsible for supplying accurate and current insurance information. I authorize a photocopy of this statement to serve as an original.

Signature: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature :_____

If you are not the patient, please specify your relationship to the patient: _____