PRISAT, P.A
Prita Madkaiker, M.D.
Diplomate of American Board of Internal Medicine
3685 Crown Point Court, Jacksonville, FL 32257
Ph 292-4129 Fax 268-3293

Welcome to our practice. We are happy to take care of your medical needs.We do not do Auto claims, Worker's comp claims, any legal claims or issue.

1)PAPERWORK: Please complete the enclosed paperwork and bring with you to your first appointment.
Please bring your photo ID and insurance cards to each appointment. Notify us with any change of insurance plans. If you are self pay patient you only require a photo ID.

2)PAYMENTS

WE DO NOT ACCEPT CHECKS FROM NEW PATIENTS ON FIRST VISIT.
You can pay by: cash, credit cards, money orders, VISA check cards. If you only bring your checkbooks with you, you will be directed to the nearby PUBLIX that cashes personal checks.

Co-Pays will required before the visit as required by law. There will be a $25 fee for cancelled visits. Please notify us 24 hr in advance if you would like to cancel or reschedule your visit.

3) INSURANCE VERIFICATION: To allow proper time for insurance verification, we encourage you to arrive a minimum 30 minutes prior to your scheduled appointment.

We look forward to meeting you.

Regards,
Prita Madkaiker, M.D. & staff.

NOTICE OF PRIVACY PRACTICES

PATIENTS - PLEASE RETAIN THESE TWO PAGES FOR YOUR RECORDS.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is not in effect.

We Have the Right To:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assistant in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting accreditation, certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposed in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, or Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations

for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations of proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the forms you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations, and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes and to include the changed in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at this office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or think that we may have violated your privacy rights, please contact us at: Privacy Office; PRISAT, PA; PO Box 24331; Jacksonville, FL 32241-4330. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRISAT, P.A.
Prita Madkaiker, M.D.
3685 Crown Point Court, Jacksonville, Fl 32257

PATIENT INFORMATION.

Patient's Full Name _____
Date of Birth _____ SSN :_____
Sex _____ Male _____ Female
Marital Status _____ Single _____ Married _____ Divorced _____ Widow/Widower
Home Address

_____
_____
_____

Phone No : Home _____ Work _____
Cell _____ Email _____
OK to leave Message _____Yes _____ No , If yes which number _____
Driver's license # _____ State Issuing _____
EMPLOYMENT INFORMATION.
Employer _____
Occupation _____
Address _____
_____
_____

EMERGENCY CONTACT INFORMATION

Emergency contact _____
Relationship _____
Phone No _____
Address _____
_____
_____

INSURANCE INFORMATION

PRIMARY INSURANCE

It is your responsibility to check with your insurance regarding pre-authorization or referral before your appointment begins.

Relationship to insured _____ Self _____ Spouse/Partner _____ Other

Insurance Name _____
Policy/Contract No _____ Group No _____
Employer Name _____

If you are Dependent on the insurance policy, please complete the following
Insured's full name _____
Insured's Date of Birth _____ Insured's SSN : _____
Insured's Home Address

_____
_____
_____

SECONDARY INSURANCE

Relationship to insured _____ Self _____ Spouse/Partner _____ Other

Insurance Name _____
Policy/ Contract No _____ Group No _____
Employer Name _____

If you are Dependent on the insurance policy , Please complete the following.
Insured's full name _____
Insured's Date of Birth _____ Insured's SSN : _____
Insured's Home Address

_____
_____
_____

ANY OTHER INSURANCE INFORMATION / PLEASE ADD BELOW.

_____
_____
_____
_____
_____

RESUSCITATION STATUS (CODE STATUS)

I would like the following procedures followed if in case of emergency I am not able to make any of the following decisions. I understand I can change my mind about the following anytime. In case of emergency if I pass out or not able to breathe the following procedures may be done.

YES	NO	PROCEDURES
____	_____	CHEST COMPRESSIONS/ CPR
____	_____	BREATHING TUBE/ VENTILATOR
____	_____	CARDIAC MEDICATIONS
____	_____	DEFIBRILLATOR/ SHOCK TO HEART
____	_____	DO NOT RESCUSITATE

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

PRISAT, PA.

Controlled Medications Agreement.

I, _____ agree to abide by the following rules regarding the dispensing of prescription for controlled medications.

Controlled medications will be not dispensed in the office by any staff other than the provider by a written prescription.

We will not be calling in prescriptions that are not due before the time.
Controlled medication prescription will not be called in the pharmacy after office hours or on the weekends or holidays when the office is closed.

Patients need to call in for request for refills for controlled medications 4 days or more prior to giving out. It is upto the provider discretion to refill it or need to call in a patient for a visit prior to authorization.

Once the prescription is written the patient is responsible to take medications as prescribed, not run out of it due to either taking too many or losing medications.

The practice is not responsible for lost prescriptions, stolen scripts or lost medications. It is the patient responsibility to take care of medications and keep it in secured place.

Any breach in agreement of the above may result in termination of the patient to the practice as decided by the provider.

I understand the above agreement and given the opportunity to ask any questions. My questions were answered by the staff satisfactorily.

Patient signature :_____ Date _____

Physician signature : _____

PRISAT . P.A.
Prita Madkaiker, M.D.
3685 Crown Point Ct
Jacksonville, Fl 32257

GENERAL CONSENT FOR TREATMENT

I request and authorize medical care from my physician, his assistant or designees that may deem necessary or advisable. This care may include, but not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine medications, biological and other therapeutics, and routine medical and nursing care. I authorize the practice to perform other additional or extended services in emergency situations if it may be necessary or advisable to preserve my life or health.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.

I understand and have been informed that an HIV test may be performed on me without my consent if a health professional or employee of the practice sustains an exposure to my blood or other body fluid.

I understand that as a part of my healthcare , PRISAT.P.A ,originates, maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information serves as a basis for planning my care and treatment,
A means of communication among the health professionals who contribute to my care
A source of information for applying my diagnosis to my bill
A means by which a third-party payer can verify that services billed were actually provided.

I hereby authorize and instruct my insurance carrier to make payments directly to PRISAT.PA. and its providers for benefits otherwise payable to me. I agree to personally pay for any charges that are covered by or collected from any insurance company, including any deductibles and coinsurance amounts.

ACKNOWLEDGMENT OF PRIVACY PRACTICES.

I understand that my protected health information , including information about HIV, AIDS, substance abuse treatment records may be disclosed to health professionals who contribute to my care and treatment. I have been offered an opportunity to review the Notice before signing this consent. I have had the opportunity to ask questions and had these questions addressed.

Signature of Patient_____ Date _____

Name of Patient _____

PRISAT, PA.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the release of my medical records for the continuity of my care as needed by the providers of PRISAT, PA. I understand that the records will be kept confidential as per the HIPPA regulations and only be used as necessary for the management and co-ordination of my health care.

To :

_____

_____

_____

_____

Please release my healthcare information to,

PRITA MADKAIKER, MD.
3685 Crown Point Court,
Jacksonville, Fl 32257.
Ph 292-4129
Fax 268-3293/ 880-8840

Please release the following information of:

_____ History/Physical _____ Last 3 Progress Notes.

_____ Laboratory Tests _____ Radiology / Diagnostic Testing.

_____ HIV results _____ Hospitalization records.

_____ Mental Health records _____ Consultation / Specialist reports.

_____ Medication History _____ Drug / Etoh history

_____ Other. Specified _____

Patient's Name: _____ **DOB** _____ **SSNo** _____

Patient Signature _____ Date _____

Legal/ Guardian/ POA _____ Date _____

Reason patient not able to sign_____

Witness _____ Date _____