CONTACT PREFERENCES

THE FOLLOWING ARE WAYS UMAMAHESWARA R. VEJENDLA, M.D. PC MAY COMMUNICATE INFORMATION WITH YOU. PLEASE MARK YOUR PREFERENCES BY CHECKING EITHER YES OR NO FOR EVERY OPTION. IF LEFT BLANK, THAT OPTION WILL AUTOMATICALLY BE CHECKED YES IN YOUR RECORD.

BY SIGNING THIS FORM, YOU UNDERSTAND THAT PERMISSION TO CONTACT YOU VIA U.S. POSTAL SERVICES 'MAIL' IS *MANDATORY* AND IS AUTOMATICALLY CHECKED YES.

Name: _____ DOB: _____

_____ _____

Patient Signature (Parent/Guardian if minor patient) ***Date***

****

I GIVE PERMISSION TO LEAVE APPOINTMENT INFORMATION:

	YES	NO
Home Phone (Include Auto Call)		
Cell Phone (Include Auto Call)		
Mobile Text (Include Auto Call)		
Work Phone		
With Another Person		
Send via Mail	XX	
Send via Patient Portal		

I GIVE PERMISSION TO LEAVE ROUTINE AND/OR NORMAL TEST RESULTS:

	YES	NO
Home Phone (Include Auto Call)		
Cell Phone (Include Auto Call)		
Mobile Text (Include Auto Call)		
Work Phone		
With Another Person		
Send via Mail	XX	
Send via Patient Portal		

****

Person(s) authorized to communicate my Private Health Information (PHI) with if any:

O Check circle if this person is also an **EMERGENCY CONTACT**

	Name	Relationship	Phone
O	_____	_____	_____
O	_____	_____	_____
O	_____	_____	_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

UMAMAHESWARA RAO VEJENDLA, M.D. PC | 152 Foote Avenue, Jamestown, NY 14701| Phone: (716) 664-5290 | Fax: (716) 664-7630

1. Patient's Name:	2. Date of Birth:
3. Patient's Address:	Phone Number:

I, or my legally authorized personal representative, request that health information regarding my care and treatment be disclosed as set forth on this form. In accordance with New York State lad and the Privacy Rule of the Health Information Portability and Accountability Act (HIPAA) of 1996, I understand that:

This authorization may include disclosure of information relating to *records from alcohol/drug treatment programs, records from mental health programs,* and confidential *HIV/AIDS-related information* only if I place my initials on the appropriate line in box 5 below. In the event the health information described below includes any of these type of information, and I initial the items in box 5, I specifically authorize disclosure of such information to the person or persons indicated in box 7. If I am authorizing the disclosure of records from alcohol/drug treatment programs, mental health programs, and confidential HIV/AIDS- related information, that recipient is prohibited from disclosing such information about my authorization unless permitted to do so under Federal or State law. If I believe my rights have not been protected, I may contact the New York State Division of Human Rights at (888) 392-3644.

This authorization is voluntary and I have the right to refuse to sign it. My treatment will not be conditioned upon my authorization of this disclosure.

I have the right to revoke this authorization at any time by writing to the healthcare provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Information disclosed might be disclosed by the recipient except as noted above, and this disclosure may no longer be protected by Federal or State law.

This authorization does not authorize disclosure of my health information or medical are with anyone other than the person or persons specified below in box 7.

I may be charged a fee of up to $0.75 per page if I am requesting a copy of my records for my own personal use.

4. I authorize the disclosure of health information (written or oral) of the individual named above (in box 1) for the following purpose:

- ☐ For medical care
- ☐ Lab and/or x-ray results
- ☐ To share health information with another individual
- ☐ Other (please describe): _____
- ☐ For billing purposes
- ☐ For insurance purposes

5. The type of information to be disclosed is as follows. Please check the appropriate items below:

- ☐ Last 2 years of records
- ☐ Lab and/or x-ray results
- ☐ Immunizations records
- ☐ Other, please describe: _____

Include (indicate by initialing)

- _____ **Records from alcohol/drug treatment programs**
- _____ **Clinical records from mental health programs**
- _____ **HIV/AIDS- related information**

6. Please disclose the information above FROM:

Healthcare Provider: _____
Address: _____
Phone: _____
Fax: _____

☐ Individual (relationship): _____
☐ Organization: _____
Address: _____
Phone: _____
Fax: _____

7. Please disclose the information above TO: Umamaheswara Rao Vejendla, M.D, PC, 152 Foote Ave, Jamestown, NY 14701, Ph: 716-664-5290, Fax: 716-664-7630

Note: Our practice can receive electronic records via email (CCDs) by using this address: https://sendsafe.to/billing.vejendla@gmail.com

8. Unless previously revoked by me, the specific information authorized here may be disclosed from _____ (start date) until _____(expiration date) or _____ (expiration event).

9. _____ _____

Signature of patient or personal representative authorized by law **Date**

******If personal representative, relationship to patient (please print)** _____

Chautauqua County Health Network

NEW YORK HEALTH CARE PROXY

(1) I, _____, hereby appoint: _____
(print your name)

_____
(print name, home address and telephone number of agent)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

_____

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(print name, home address and telephone number of agent)

(4) Donation of Organs at Death:

[ ] I **do** **not** wish to donate my organs, tissues or parts.

[ ] I **do** wish to be an organ donor.

(5) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

_____

_____

(6) Signature:_____ **Date:**_____
Address:_____
Telephone Number: ( ) _____ **Date of Birth:**_____

Statement by Witnesses (must be 18 or older)
I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him/her) this document in my presence. I am not the person appointed as proxy by this document.

Witness 1:_____
Address:_____
Witness 2:_____
Address:_____

I consent to releasing this information to the Health Care Proxy Registry.
Signature:_____ Date:_____

County Health Network
strengthening and promoting quality health care

TO COMPLETE YOUR HEALTH CARE PROXY WE OFFER A 5 STEP PROCESS

1. Think about what is important to you and what health care wishes you want carried out if you are unable to communicate for yourself.

2. Appoint a health care agent, a person to speak for you should you be unable to speak for yourself.

3. Talk to your agent and family about your wishes.

4. Put your wishes in writing using a Health Care Proxy Form (see reverse side)

5. If you receive health care services in Chautauqua County, New York and would like your Health Care Proxy to be available online to area healthcare professionals:

   - Mail a completed copy of your Health Care Proxy to:
     CCHN
     200 Harrison Street, Suite 200
     Jamestown, New York 14701

   - Fax to 338-9740 for free entry in the Chautauqua County Health Network Proxy Registry.

   - Give a completed copy to your health care provider.

To learn more about Health Care Proxies call:

Chautauqua County Health Network
strengthening and promoting quality health care
716.338.0010

UMAMAHESWARA R. VEJENDLA, PHYSICIAN PC
152 FOOTE AVE.
JAMESTOWN, NY 14701
PHONE: (716) 664-5290 - FAX: (716) 664-7630

MEDICAL HISTORY

DATE:_____

PATIENT NAME: _____
(LAST) (FIRST) (MI)

SSN:_____ BIRTHDATE:_____

CURRENT STATUS: ☐MARRIED ☐SINGLE ☐OTHER

MEDICAL HISTORY (LIST ALL YOUR KNOWN MEDICAL CONDITIONS)

☐ASTHMA	☐HYPERTENSION	☐DEPRESSION	☐ANXIETY	☐PSYCHIATRIC DISORDER
☐ULCERS	☐HEART BURN	☐DIABETES	☐SEIZURES	☐URINATING DIFFICULTIES
☐MIGRAINE	☐HEART DISEASE	☐CANCERS	☐THYROID	☐ELEVATED CHOLESTROL
☐HAY FEVER	☐BLOOD CLOTS	☐HEPATITIS B	☐HEPATITIS C	☐BLEEDING DISORDER

OTHER: (PLEASE SPECIFY)_____

*ALLERGIES_____

PERFERRED PHARMACY:_____

CURRENT MEDICATIONS: (LIST ALL MEDICATIONS AND DOSE YOU ARE TAKING- INCLUDE VITAMINS & HERBAL SUPPLEMENTS)

_____
_____
_____
_____

DATE OF LAST PREVENTATIVE:

*PHYSICAL: MO/YEAR_____

*COLONOSCOPY: MO/YEAR_____

(FEMALE ONLY)

*MAMMOGRAM: MO/YEAR_____

*PAP: MO/YEAR_____

SURGERY/INJURY (LIST PREVIOUS SURGERIES OR INJURIES AND APPROXIMATE YEAR)

SURGERY/INJURY	YEAR	SURGERY/INJURY	YEAR

HOSPITALIZATION (LIST REASONS FOR ANY PREVIOUS HOSPITAL ADMISSION & APPROXIMATE YEAR)

REASON	YEAR	REASON	YEAR

***Please complete reverse side of this form. ***

Umamaheswara Rao Vejendla, M.D., P.C.
152 Foote Avenue, Jamestown, New York, 14701

Phone: (716) 664-5290
Fax: (716)664-7630

FAMILY HISTORY

FATHER: ☐ALIVE ☐DECEASED	PRESENT HEALTH OR CAUSE OF DEATH	AGE?
MOTHER: ☐ALIVE ☐DECEASED	PRESENT HEALTH OR CAUSE OF DEATH	AGE?
BROTHERS ☐ALIVE ☐DECEASED	PRESENT HEALTH OR CAUSE OF DEATH	AGE?
SISTERS ☐ALIVE ☐DECEASED	PRESENT HEALTH OR CAUSE OF DEATH	AGE?

FAMILY HISTORY CONTINUED: (PLEASE CHECK MEDICAL PROBLEMS OF IMMEDIATE FAMILY)

MEDICAL COMPLAINTS	MOTHER	FATHER	SIBLING(S)	COMMENTS- AGE?
HEART ATTACK				
DIABETES				
CANCER (TYPE)				
OSTEOPOROSIS				
STOKE				
HIGH BLOOD PRESSURE				
KIDNEY DISEASE				
COLON POLYPS				
HIGH CHOLESTEROL				
THYROID DISEASE				
DEPRESSION				
OTHER- PLEASE LIST DISEASE				

OTHER:

TOBACCO USE: ☐YES ☐NO (PACKS/DAY)_____

ALCOHOL USE: ☐YES ☐NO (DRINKS/WEEK)_____

EXERCISE: ☐YES ☐NO (TIMES/WEEK)_____

RECREATIONAL DRUGS: ☐YES ☐NO (TYPE/FREQUENCY)_____

DO YOU HAVE ADVANCED DIRECTIVES: ☐YES ☐ NO

IF NOT, ARE YOU INTERESTED IN DISCUSSING THIS?☐ YES ☐NO

DO YOU HAVE AN ORDER OF DNR?☐ YES☐ NO

IF NOT, ARE YOU INTERESTED IN DISCUSSING THIS? ☐YES ☐NO

DO YOU HAVE A HEALTH CARE PROXY? ☐YES ☐NO

PERSONAL INFORMATION FORM

FULL NAME: (LAST,FIRST,MI)	PREFERRED NAME:

PRIMARY ADDRESS: (STREET, CITY, STATE, ZIP CODE)

MAILING ADDRESS: (STREET,CITY,STATE,ZIP CODE)

DATE OF BIRTH:	MARITAL STATUS:	TELEPHONE NUMBERS/CONTACT INFO.
	☐SINGLE ☐OTHER	HOME: _____
____/____/____	☐MARRIE _____	CELL: _____
	☐DIVORCED	WORK: _____

OCCUPATION: _____

EMPLOYMENT STATUS: _____

PRIMARY CAREGIVER: _____

SEX AT BIRTH:

- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

PRONOUN:

- ☐ HE
- ☐ SHE
- ☐ THEY

GENDER IDENITY:

- ☐ MALE
- ☐ FEMALE
- ☐ TRANSGENDER MALE
- ☐ TRANSGENDER FEMALE
- ☐ NEITHER EXCLUSIVELY MALE NOR FEMALE
- ☐ NOT SURE/QUESTIONING
- ☐ ADDITIONAL GENDER CATEGORY/OTHER
  PLEASE SPECIFY: _____
- ☐ DECLINE TO SPECIFY

SEXUAL ORIENTATION:

- ☐ STRAIGHT OR HETEROSEXUAL
- ☐ LESBIAN, GAY, OR HOMOSEXUAL
- ☐ BISEXUAL
- ☐ QUEER
- ☐ PAN SEXUAL
- ☐ ASEXUAL
- ☐ SOMETHING ELSE, PLEASE DESCRIBE:

  _____
- ☐ DON'T KNOW
- ☐ DECLINE TO SPECIFY

ENTHNICITY (PLEASE SELECT ONE)

- ☐AMERICAN INDIAN/ALASKA NATIVE
- ☐ASIAN/PACIFIC ISLANDER
- ☐AFRICAN AMERICAN/BLACK
- ☐WHITE
- ☐HISPANIC
- ☐UNSPECIFIED

PREFERRED LANGUAGE

- ☐ENGLISH
- ☐SPANISH
- ☐ASL
- ☐OTHER (PLEASE SPECIFY)

MEDICAL INSURANCE INFORMATION:

INSURANCE COMPANY NAME:	
INSURANCE ID#	GROUP#
POLICY HOLDER'S NAME:	POLICY HOLDER RELATIONSHIP TO PATIENT:
POLICY HOLDER'S ADDRESS:	POLICY HOLDER'S DATE OF BIRTH: / /
	POLICY HOLDER'S SOCIAL SECURITY: - -
	POLICY HOLDER'S EMPLOYER:

AMA | STEPSforward

Pre-appointment questionnaire

To be completed before or at the patient's current visit	
Patient name:	
Date of birth:	Appointment Date:

What do you hope to accomplish today?

Is there anything you would like to work on to improve your health?

Please respond if you have one of the following conditions:

High Cholesterol	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A
Diabetes	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home glucose readings:
High Blood Pressure	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home blood pressure readings:
Depression	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Any suicidal thoughts? ☐ No ☐ Yes ☐ N/A

Have you been to the emergency room, hospital or any other provider since your last visit?
If yes, please explain:

Lifestyle

Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week
☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often? How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often? How long?

Smoking

Do you smoke? ☐ No ☐ Yes: How often? How much?

Birth control

Do you use any form of birth control? ☐ No ☐ Yes: What method?

Medication adherence

Do you have trouble taking any of your medications? ☐ No ☐ Yes: Describe.

Lifestyle

Are there any changes to your family medical history? For example, if a family member has received a new diagnosis, we can update your family history to reflect any changes since your last visit.

Have you recently developed an allergy to any of your medications? If yes, please describe below.

Do you have any end-of-life care plans or preferences? If yes, please bring a copy of relevant documents to your upcoming visit (e.g., your advance directive, power of attorney and health care proxy). If not, would you like to discuss your preferences?

Are you experiencing any of the following?

☐ Abdominal pain	☐ Diarrhea	☐ Headache	☐ Runny nose
☐ Anxiety	☐ Double vision	☐ Heart palpitations	☐ Shortness of breath
☐ Blood in stools	☐ Ear pain	☐ Heat/cold intolerance	☐ Sore throat
☐ Bloody urine	☐ Enlarged lymph nodes	☐ Impotence	☐ Sudden vision loss
☐ Breast mass	☐ Excessive thirst	☐ Irregular menses	☐ Suicidal thoughts
☐ Bruising	☐ Extreme fatigue	☐ Joint pain	☐ Vomiting
☐ Changing mole	☐ Falling	☐ Muscle weakness	☐ Unusual bleeding
☐ Chest pain	☐ Fever	☐ Nausea	☐ Weakness
☐ Constipation	☐ Frequent urination	☐ Numbness	☐ Weight loss
☐ Cough	☐ Hay fever	☐ Painful urination	☐ Wheezing
☐ Depression			

Do you have any other concerns? If yes, please describe below.

Umamaheswara Rao Vejendla, M.D., P.C.
152 Foote Avenue, Jamestown, New York, 14701

Phone: (716) 664-5290
Fax: (716)664-7630

UMAMAHESWARA RAO VEJENDLA PHYSICIAN PC

FINANCIAL POLICY

Our financial policy is to advise of fees relating to the collection of payments from our patient and/or their insurance company. These policies are as follows:

1. All co-pays or coinsurance are due at the time of service. If the insurance does not pay du to the termination of the patient's policy or if there is an outstanding balance due to a deductible, the patient is responsible for the balance. Payment in full is required if Dr. Vejendla does not participate with your insurance company. Our office does not bill for liability cases. We will provide a statement to you to forward after payment is made in full. For our patients who are self-pay, payment in full is required at the time of service. Prior arrangements ***must*** be made with our Billing Manager if payment in full cannot be made at the time of service.

2. Allowable forms of payment are cash, check, money order, and Mastercard or Visa. A returned check for non-sufficient funds will result in a $35.00 fee in addition to the amount of the check.

3. Monthly statements are sent for balances due after the insurance has processed your claim. If the statement is not paid within the first 30 days, then subsequent statements will include a $2.00 finance charge. We will only mail out 4 statements. ***If your balance is not paid within that time frame, the account will be sent to our collection agency and an additional 35% of the balance will be assessed to you as well as any legal fees that incur.***

4. APPOINTMENTS: If you are unable to keep an appointment, please provide our office with a minimum 24 hour notice. Appointments cancelled with less than a 24 hour notice will be charged a $25.00 fee. Appointments that re not cancelled at all (e.g., "No Shows") will be charged a fee of $25.00. If you have 3 "No Shows" or cancels without a 24 hour notice, you will be released by our practice and non-payment will result in collection actions.

5. Patients who are referred to our office by another doctor must bring a referral for the services if their insurance requires one. Failure to get a referral can result in a rescheduled appointment.

6. Patients who request their records be transferred out of our office must sign a transfer request. Our fee for transferring records is $0.75 per page. Any unpaid balance at the time of transferring records should be paid or it will be sent to our collections agency.

Signature of Patient/Authorized Representative ***Date***

By signing above, I acknowledge that I have read this policy and understand it to the best of my ability.

Umamaheswara Rao Vejendla, M.D., P.C.
152 Foote Avenue, Jamestown, New York, 14701
Phone: (716) 664-5290
Fax: (716)664-7630

Our Practice Policies

Our Policies have been set in place to ensure that each patient's visit runs smoothly and that your needs are met.

1. For *any* medication refills:
   - Please give our office a 24 to 48 hour notice prior to the time the refill needs called in or picked up.
2. Late Arrivals:
   - Please arrive 15 minutes early to each appointment and if you are going to be late call us at (716) 664-5290 and notify us as soon as possible. Upon arriving late, you may have to wait to be fit into the schedule or be asked to reschedule for a different day.
3. No Show Policy:
   - The first appointment that is a no show will result in a verbal reminder of our policy to cancel at minimum of 24 hours in advance of any appointment made with us. A second no show will result in a $25.00 fee that is not payable by any insurance and will need to be paid in full prior to your next scheduled appointment. If there is a third no show within 1 calendar year, you will be discharged from our practice.
4. Please bring your insurance card(s) to every visit and be prepared to answer a series of questions to update your information each appointment.
5. Your Co-Pay, Deductible, Co-Insurance, and any outstanding balance past 30 days are due at the time of service.
6. Voicemails:
   - If you call our office and are sent to a voicemail box, please leave a message. We check our message regularly throughout the day and will return all phone calls by the end of the business day. Please be sure to speak clearly, slowly, and to leave your name, date of birth, reason for your call, and a phone number you can be reached at.
7. When calling the office, only press phone option "1" for the emergency line if you have a true emergency. Prescription refills and appointments are not considered emergencies.
8. Please bring an updated medication list to each visit. A medication list is a list of all medications you are currently taking including any over the counter medications.
9. Please turn off cell phones while in the exam room.
10. Paperwork:
    - We require 1 business week to complete all paperwork and will contact you via phone when it is ready to be picked up. There is a $20 fee for paperwork that needs to be completed for someone who is not a patient at our practice and $10 for all patients. Medical records can be sent to another doctor/care facility free of charge, however there is a $0.75 per page fee for personal use.

Our office will do its best to run on time, however there may be times you will have to wait longer than expected so that each patient receives the care they need. Also, please be aware that there are multiple providers, each with their own schedule. You will be seen in the order you were scheduled. We appreciate your patience and understanding.

_____

Signature of Patient/Authorized Representative ***Date***

By signing above, I acknowledge that I have read this policy and understand it to the best of my ability.

Umamaheswara Vejendla, M.D., P.C.
152 Foote Avenue
Jamestown, New York 14701
(716) 664-5290

WELCOME TO OUR OFFICE

Due to the continuing changes in the healthcare industry we would like to provide you with our practice billing policies and how they relate to you.

Our office participates in the following insurance companies:

Medicare	INDEPENDENT HEALTH
Empire BC/BS	UNIVERA
BC/BS WNY	FIDELIS
GHI	MEDICAID
AARP	AETNA
UNITED HEALTHCARE	HEALTH AMERICA

If we do not participate with your insurance carrier: We will file the claim if you provide us with the following information: Name and mailing address of your insurance carrier, policy number, group number, policy holders' full name, policy holders' date of birth and social security number. We file these claims as a courtesy to our patients so that your insurance carrier reimburses you in a timely manner. We will bill your insurance company only once per service, the responsibility of the service remains the patient's responsibility. The patient is responsible to pay the bill within 30 day of the service date.

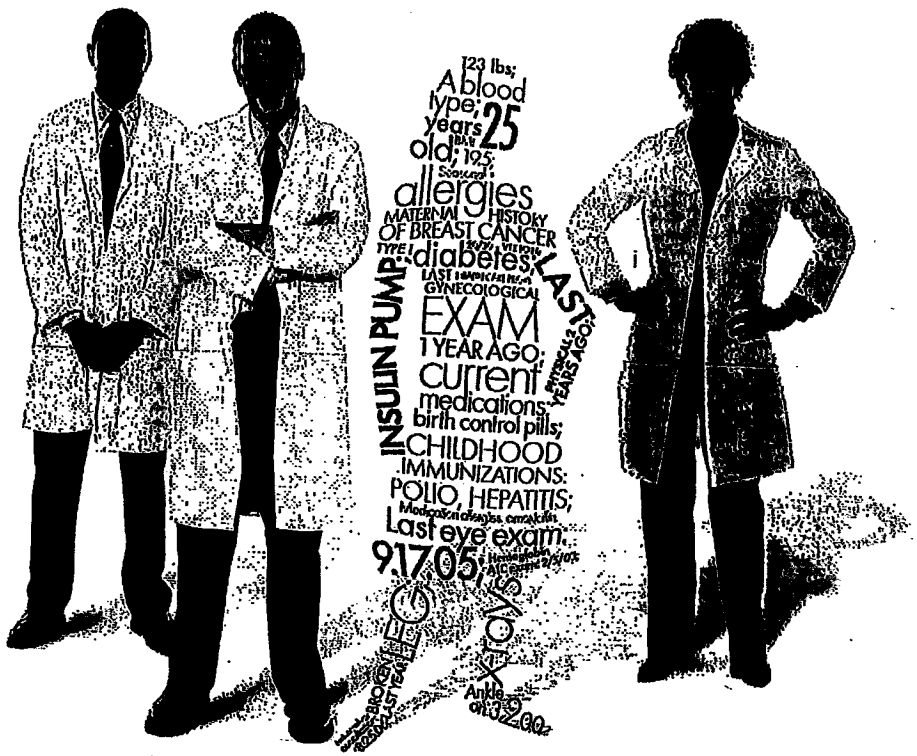
LAB WORK & HOSPITAL PROCEDURES: Please be advised that many insurance companies require you to go to a certain lab and/or hospital. **YOU** will be responsible to pay your bill if you go to a lab and/or hospital that is not covered by your insurance carrier. Please check with your insurance company to see where you should go for these services.

If you have no insurance coverage: **Payment must be made at the time of the service** unless an acceptable payment plan has been agreed upon staff **prior** to the services rendered.

We welcome you to our practice and look forward to providing your medical care. Please do not hesitate to ask our staff if you have any questions regarding the above information.

Sincerely,

Umamaheswara Vejendla, M.D., P.C.



Lifesaving information, right at doctors' fingertips. That's HEALTHeLINK.

Your medical history. It's lengthy, detailed, and extremely important. And to provide you with the care you need, your doctor should have quick, easy access to it. Makes sense, right?

This is the thinking behind HEALTHeLINK.

HEALTHeLINK facilitates the accurate, secure exchange of clinical information among healthcare professionals. In other words, we help doctors obtain the answers they need right when they need them. No more waiting, no more guesswork, no more hassle. We save physicians time and money. We help them provide better, more efficient care. And we help them save lives.

All your data, from head to toe.

Sure, HEALTHeLINK will undoubtedly make doctors' jobs easier. But what does it mean for you? Well, if you've ever tried to remember the result of your last cholesterol test, or had to guess which medications you've been on, those days are over. Most important, should there ever be a situation in which you are unable to provide answers, your body of information can do the talking for you.

Ultimately, HEALTHeLINK will improve the care you receive and maybe even save your life one day.

An eye on security.

When sharing any personal data electronically, there are going to be questions and concerns. Well, you can rest assured privacy and safety are of the utmost importance to us. HEALTHeLINK wouldn't work any other way. We employ strict security measures, and only those authorized will be granted access to your information.

We need a hand from you.

Only you can provide medical professionals with the authorization to access the information they need to care for you more effectively. The more people who get onboard – patients and doctors alike – the more effective a tool HEALTHeLINK will prove to be. That's why we're asking you to do your part and sign the consent form available at your physician's office. Or call (716) 206-0993 ext. 311 and we'll provide you with one. You can also call with any questions you may have about HEALTHeLINK, or simply visit www.wnyhealthelink.com.

If you have any questions about HEALTHeLINK call (716) 206-0993 ext. 311 today.

HEALTHeLINK

HEALTHeLINK

HEALTHeLINK is a not-for-profit organization and is governed by healthcare providers, insurers, and representatives from the Western New York community. Our mission is to provide fast, secure access to clinical information to improve quality and control healthcare costs for our community.

Give your doctor instant access to your body of information.

HEALTHeLINK

Umamaheswara Rao Vejendla, M.D., P.C.
152 Foote Avenue, Jamestown, New York, 14701

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FINANCIAL POLICY

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1. All co-pays or coinsurance are due at the time of service. If the insurance does not pay du to the termination of the patient's policy or if there is an outstanding balance due to a deductible, the patient is responsible for the balance. Payment in full is required if Dr. Vejendla does not participate with your insurance company. Our office does not bill for liability cases. We will provide a statement to you to forward after payment is made in full. For our patients who are self-pay, payment in full is required at the time of service. Prior arrangements *must* be made with our Billing Manager if payment in full cannot be made at the time of service.

2. Allowable forms of payment are cash, check, money order, and Mastercard or Visa. A returned check for non-sufficient funds will result in a $35.00 fee in addition to the amount of the check.

3. Monthly statements are sent for balances due after the insurance has processed your claim. If the statement is not paid within the first 30 days, then subsequent statements will include a $2.00 finance charge. We will only mail out 4 statements. *If your balance is not paid within that time frame, the account will be sent to our collection agency and an additional 35% of the balance will be assessed to you as well as any legal fees that incur.*

4. APPOINTMENTS: If you are unable to keep an appointment, please provide our office with a minimum 24 hour notice. Appointments cancelled with less than a 24 hour notice will be charged a $25.00 fee. Appointments that re not cancelled at all (e.g., "No Shows") will be charged a fee of $25.00. If you have 3 "No Shows" or cancels without a 24 hour notice, you will be released by our practice and non-payment will result in collection actions.

5. Patients who are referred to our office by another doctor must bring a referral for the services if their insurance requires one. Failure to get a referral can result in a rescheduled appointment.

6. Patients who request their records be transferred out of our office must sign a transfer request. Our fee for transferring records is $0.75 per page. Any unpaid balance at the time of transferring records should be paid or it will be sent to our collections agency.

PATIENT COPY- RETAIN FOR YOUR RECORDS

Umamaheswara Rao Vejendla, M.D., P.C.
152 Foote Avenue, Jamestown, New York, 14701
Fax: (716)664-7630

Our Practice Policies

Our Policies have been set in place to ensure that each patient's visit runs smoothly and that your needs are met.

1. For *any* medication refills:
   - Please give our office a 24 to 48 hour notice prior to the time the refill needs called in or picked up.
2. Late Arrivals:
   - Please arrive 15 minutes early to each appointment and if you are going to be late call us at (716) 664-5290 and notify us as soon as possible. Upon arriving late, you may have to wait to be fit into the schedule or be asked to reschedule for a different day.
3. No Show Policy:
   - The first appointment that is a no show will result in a verbal reminder of our policy to cancel at minimum of 24 hours in advance of any appointment made with us. A second no show will result in a $25.00 fee that is not payable by any insurance and will need to be paid in full prior to your next scheduled appointment. If there is a third no show within 1 calendar year, you will be discharged from our practice.
4. Please bring your insurance card(s) to every visit and be prepared to answer a series of questions to update your information each appointment.
5. Your Co-Pay, Deductible, Co-Insurance, and any outstanding balance past 30 days are due at the time of service.
6. Voicemails:
   - If you call our office and are sent to a voicemail box, please leave a message. We check our message regularly throughout the day and will return all phone calls by the end of the business day. Please be sure to speak clearly, slowly, and to leave your name, date of birth, reason for your call, and a phone number you can be reached at.
7. When calling the office, only press phone option "1" for the emergency line if you have a true emergency. Prescription refills and appointments are not considered emergencies.
8. Please bring an updated medication list to each visit. A medication list is a list of all medications you are currently taking including any over the counter medications.
9. Please turn off cell phones while in the exam room.
10. Paperwork:
    - We require 1 business week to complete all paperwork and will contact you via phone when it is ready to be picked up. There is a $20 fee for paperwork that needs to be completed for someone who is not a patient at our practice and $10 for all patients. Medical records can be sent to another doctor/care facility free of charge, however there is a $0.75 per page fee for personal use.

Our office will do its best to run on time, however there may be times you will have to wait longer than expected so that each patient receives the care they need. Also, please be aware that there are multiple providers, each with their own schedule. You will be seen in the order you were scheduled. We appreciate your patience and understanding.

PATIENT COPY- RETAIN FOR YOUR RECORDS