Sumit Dewanjee, MD
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Tempe, AZ 85281
Telephone 480.449.3979 Fax 480.718.9824

New Patient Form

Name: _____
(First) (Middle) (Last)

Date of Birth _____ Social Security # _____

Responsible Party if a minor/ Relationship _____

Address _____ Suite/Apt _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Permission to leave voice message? ☐ Yes ☐ No Email Address _____

How would you prefer to have your future appointments confirmed: By Phone Call ☐ By TextMsg ☐

In Case of Emergency, Notify _____

Phone # _____ Relationship _____

What are we treating you for? _____

Please share how you heard about FX RX _____

Primary Care Physician _____

Primary Care Phone _____ Primary Care Fax _____

Please specify the following: ☐Health Insurance ☐Workers Compensation ☐Attorney Lien

Primary Insurance Name: _____ Relationship to Insured: _____

Policy Holder Name: _____ Policy Holder DOB: _____ / _____ / _____

Secondary Insurance Name: _____ Relationship to Insured: _____

Policy Holder Name: _____ Policy Holder DOB: _____ / _____ / _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FX RX, INC. or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Today's Date:_____

FX RX INC.
DR. SUMIT DEWANJEE

Authorization for Release of Information: I authorize FX RX Inc. to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Workman's compensation care.

Medicare/AHCCCS Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding treatment and services provide as stated below.

Assignment of Benefits: I hereby authorize payment directly to FX RX Inc. by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance: FX RX Inc. will file your insurance as a service to you. If our billing office does not hear from your insurance within 60 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by FX RX Inc., I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles and any services not covered by my insurance. I also understand that I am financially responsible for any charges not covered by my insurance. I hereby assign to FX RX Inc. all benefits I am entitled to receive from any person, insurance company or entity to the extent of medical charges incurred by the patient or me and authorize payment of such benefits directly to FX RX Inc. In the event my account is referred to a collection agency, I will be responsible for collection costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information.

Valuables: I (we) understand that FX RX Inc. is not responsible for valuables and personal property brought to the facility.

I further acknowledge and grant to FX RX Inc. a lien pursuant to A.R.S. Section 33-932, et seq. against any recovery by me or any person on my behalf made against any liability, uninsured/underinsured motorists or other form of coverage or indemnity, or against a person or entity legally responsible for the medical charges incurred to the extent such charges are not paid in full by other available insurance or by me. R+FX RX Inc. and I also waive any attorney's fees or collection costs associated with the collection of medical charges pursuant to the lien hereby granted.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE CONSENT FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION, AND ASSIGNMENT AND PAYMENT OF SERVICES.

PRINT NAME OF PATIENT

PATIENT OR RESPONSIBLE *PARTY SIGNATURE* ***DATE***

FXRX
ORTHOPAEDICS & BRACING

Pain Medication Contract

The purpose of this contract is to prevent misunderstandings regarding specific medications you may need for pain.

I understand, that if I break this contract, **pain medication will no longer be prescribed** and I will be referred to a pain management or other specialty doctor to help taper off my medication, as necessary, to avoid withdrawal symptoms.

I agree that Dr. Dewanjee will be the only physician prescribing pain medications for me such as (Percocet, Oxycontin, Vicodin, Tramadol, etc., brand or generic) from any other physician, hospital etc.

* If Dr. Dewanjee is out of town an authorized physician covering for him may refill your prescription.

I agree to use only one pharmacy to fill my medications. I agree to give the name and phone number of my pharmacy to Dr. Dewanjee:

PHARMACY: _____ //_____ **PH#:** _____
NAME **CITY**

I will take my medication as prescribed and update this office with any changes to my medication regimen for any and all conditions.

I will not share, sell or trade my medication with anyone. **I will** safeguard my medication from loss or theft. **I am responsible** for taking my medication as prescribed. **Lost or misplaced medications will not be refilled. For a refill on stolen medication a police report must be filed and a copy provided to our office.**

Most pain medications prescribed at this office are for a duration of 15 days. **Medications will not be refilled early.**

Refills for pain medication will only be provided on **Tuesdays and Fridays. Walk in requests for medication will not be filled. A 72 hr. notice must be given prior to needing a refill. Prescriptions will not be filled after hours, over the weekend or on holidays.**

* If special circumstances arise where a prescription needs to be issued early, this can be arranged with prior notice. These prescriptions will contain post dates with the correct refill date and will not be refilled until eligible.

If you have not had an appointment with Dr. Dewanjee for more than 3 months or if you do not have a follow up appointment scheduled a refill will not be issued. An evaluation will have to be scheduled and completed by Dr. Dewanjee in order to refill your medication.

Please note the following:

While under the influence of pain medications you should **NOT** operate a motor vehicle or machinery of any kind. This could result in a DUI charge.

Post operatively pain medication will be prescribed for up to 90 days when necessary. If treatment for pain is needed for a longer period of time, a reduction in the dosage of pain medication or a referral to pain management may be necessary.

As the patient you are responsible for your and medication refills. If your pain is unmanageable over weekend/holiday/or after hours please go to your local ER for assistance.

I, _____, have read and accept understand the conditions outlined above.

_____ _____
Patient Signature Date