

SALMA MAZHAR M.D. P.A.

PATIENT REGISTRATION INFORMATION

First Name: _____ Middle: _____ Last Name: _____ Sex: M ___ F ___
Birth date: _____ Soc.Sec # _____ - _____ - _____ Driver License # _____
Address: _____ City/State/Zip: _____
Home Telephone :() _____ Cell phone () _____ Email: _____
Marital Status: _____ Referring Physician/Person: _____
Patient's Employer: _____
Address: _____ City/State/Zip: _____
Occupation: _____ Work Phone: () _____
For appointment reminders or call back request or information regarding your health, OK to leave messages on answering machine? Yes _____ No _____
Is it OK to leave messages with family members? Yes _____ No _____

SPOUSE/PARENT INFORMATION

Name: _____ Birth date: _____
Soc.Sec #: _____ - _____ - _____ Sex: M ___ F ___
Address if different than above: _____
Home Telephone: () _____ Cell phone: () _____
Employer: _____
Address: _____ City/State/Zip: _____
Occupation: _____ Work Phone: () _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Address: _____
Home Telephone: () _____ Cell phone: () _____

PRIMARY INSURANCE CARRIER

Company Name: _____ Group# _____
ID # _____ Member name: _____ Telephone: _____

SECONDARY INSURANCE CARRIER

Company Name: _____ Group# _____
ID # _____ Member name: _____ Telephone: _____

I hereby grant permission to Salma Mazhar MD. P.A. to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary ,any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to Salma Mazhar M.D P.A.

Signature of Patient (Parent if Patient is minor)

Date

SALMA MAZHAR M.D. P.A.

FINANCIAL POLICIES

Copayment and deductible payments as determined by your agreement with your insurance carrier are **due at the time of service**. We will file your insurance claim if you agree to have your insurance company pay the doctor directly for services provided. Not all insurance plans cover all services; in the event your insurance plan determines a service to be "not covered", you will be responsible for payment. Payment is due upon receipt of a statement from our office.

If you have no health insurance, payment is due at the time of service. There will be a \$25 fee for returned checks.

In fairness to other patients and the physician, we request 24 hours notice to cancel an appointment. You may be charged \$25 for a missed appointment. Missing more than two appointments without providing notice are grounds for discharge from the practice.

I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits from my insurance company.

REFERRAL REQUIREMENT

I am seeking treatment from Salma Mazhar M.D. and understand that **if** my medical insurance company requires a referral to see a specialist, I am responsible for ensuring that the referral has taken place. If I have not obtained a required referral at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by my insurance company.

NOTICE OF PRIVACY PRACTICES

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPPA")**, I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I have been informed by Salma Mazhar M.D. P.A. of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

SIGNATURE

I have read and agree to the above policies:

Patient Name

Signature

Date