Patient Information Form

Please print all information in spaces provided. Be sure to complete and sign the statement on the back of this form.

Last Name __________________________________ First Name __________________________________ MI ________

Home Address _____________________________________ City _______________________ State _____ Zip________

Primary Phone _____________________ text enabled Y N Secondary Phone _____________________ text enabled Y N

Email ____

DOB _____________ Age _______ Social Security # _____________________ M/F Marital Status ______________

Spouse's Name ____ Contact Number ___________________________

Employer Name _______________________________________ Phone ____

Employer Address_________________________________ City _______________________ State _______ Zip_________

Primary Insurance

Company Name _______________________________________

Insured Name ____

Insured DOB ____________S.S. #________________________

Relationship to insured __________________________________

Insurance ID # ____

Secondary Insurance

Company Name___________________________________

Insured Name ____________________________________

Insured DOB ___________ S.S. #____________________

Relationship to Insured ______________________________

Insurance ID #______________________________________

Person to contact in case of an emergency (outside your home)

Name____ Relationship____

Home#______________________________ Work #____________________________ Cell# _____________________________

Name____ Relationship____

Home#______________________________ Work #____________________________ Cell# _____________________________

Primary Physicians Name____ Phone #________________________________

Pharmacy Name____ Phone #_______________________________

Who referred you? ____ Phone#_______________________________

Please fill out next page

PLEASE READ THIS FORM CAREFULLY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 understand that my medical records can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I can receive upon request a notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that I may restrict how my private information is used or disclosed.

INSURANCE AUTHORIZATION/ ASSIGNMENT OF BENEFITS

I hereby authorize ZAFAR REHMANI, M.D. to furnish any information concerning my illness and treatment to all insurance companies concerned and hereby assign all payments for medical services rendered to myself and/or dependants to RASHID ZIA, M.D.

FINANCIAL RESPONSIBILITY

It is the responsibility of each insured person to know their own insurance benefits. I understand that I am financially responsible for all charges regardless of insurance coverage. I understand that all co-payments and deductibles are due at the time of service unless arranged in advance. I also understand that if this is referred to a collection agency I am responsible to pay all attorney and/or collections fees.

APPOINTMENT CANCELLATIONS

I understand that if my appointment is not cancelled within 24 hours of the appointment time, I will be responsible to pay the missed appointment fees.

CHECK RETURN FEE

There is a $25.00 fee for any checks returned for insufficient funds, stop pay or checks put on hold.

CONSENT OF TREATMENT

I hereby give consent to treatment which may include therapy and medication management for myself and/or dependents. I have legal authorization to give this consent.

MEDICATION REFILLS

Because your health care is so important this provider does not give any phone or fax refills. In order to get refills on your medication you **must** have a scheduled appointment and see the doctor in person.

MESSAGES

I understand that messages may be left via voice mail, email or text.

CONTROLLED SUBSTANCES

I understand that I must advise the doctor of any controlled substances I am prescribed by all other providers.

RELEASE OF INFORMATION

If requested by my disability insurance, Social Security Disability Determinations, sick leave company and/or school, I give consent for my and/or dependents medical information to be released upon receipt of the properly authorized forms. This will include any chemical dependency records. I will be responsible for any additional fees concerning forms, records, medical testimony, etc.

I would like my information to be shared with my primary physician: ☐ Yes ☐ No

If yes, Doctors name: ____ Address:____

City, State, Zip:____ Phone:____________________ fax:__________________________

In addition I would like the following parties to have access to my and /or dependents information:

Name: ____ Relationship:____

Name: ____ Relationship:____

Name: ____ Relationship:____

A photo copy of this document is as valid as the original. This information may only be revoked in writing.

I have read and understand the above.

Patient/ Guarantor Signature ____ Date ____