

# REGISTRATION FORM

## PATIENT INFORMATION

Patient's Last Name: Middle:		First:	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Widow <input type="checkbox"/>			
Do You Have Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security Number:	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing address:			Primary/Preferred Phone: (      )	Secondary Phone: (      )		
City:		State:	ZIP Code:			
What Pharmacy do you use?				City:		
Email Address:				Employer:		

## INSURANCE INFORMATION (PLEASE BE SURE TO GIVE YOUR CARD(S) TO THE RECEPTIONIST)

What is your Primary Insurance?				Co pay Amount:	
Policy Holder name:	Policy Holder SS #:	Birth date:	Group no.:	Policy no.:	
Policy Holder Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Other:	
What is your Secondary Ins? <input type="checkbox"/> None					
Policy Holder name:	Policy Holder SS #:	Birth date:	Group no.:	Policy no.:	
Policy Holder Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Other:	

## IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Primary Phone: (      )	Secondary Phone: (      )
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### PROTECTED HEALTH INFORMATION RELEASE

Concerning matters of my health, lab results, and appointments, I, the patient/legal representative give permission for Dr. Hashim and members of the staff to speak to and share my information with:

I do NOT want to share my information with anyone

Name	Relationship

Name	Relationship

**I  ALLOW  DO NOT ALLOW test results and other specific information regarding my care to be left on my answering machine or voicemail.**

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 Dr. Hashim and the insurance company to release any information required to process my claims.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

### Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of claim benefits to Dr. Hashim.

Claims are filed to insurance as a courtesy. However, I understand that I am financially responsible for all services rendered including for the following reasons: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company. **Failure of insurance company to pay your claim does not excuse the patient's financial responsibility. It is patient's responsibility to know what is/is not covered and to make sure insurance pays your claims in a timely fashion.**

**NSF CHARGES:** Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event a check is returned for Non Sufficient Funds we will assess a \$25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds.

**Collections Fee: If an account remains unpaid, the account will be transferred to a collections agency and a 20% fee of the overdue balance will be added to the account. This is not negotiable. The fee is the collection agency fee imposed by the agency for their cost of business.**

**Medicare:** We will file claims for you. Please note that Medicare will not pay for a variety of procedures that they do not consider medically necessary due to their regulations. Payment is expected at time of service for those procedures although they may be balance billed after insurance is filed.

**Medicaid:** We do **not** participate with Florida or any other state Medicaid program.

Your signature below signifies your understanding and willingness to comply with Dr. Hashim's office policies.

### Patient/Responsible Party Signature for Financial Policy

X \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Dr. Hashim and his staff are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

**UNDERSTANDING YOUR HEALTH RECORD/INFORMATION** - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

**YOUR RIGHTS** - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

**OUR RESPONSIBILITIES** - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

**EXAMPLES OF HOW YOUR INFORMATION IS USED** - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

**OTHER NOTICES** - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

**FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM** - If you have concerns or would like additional information, you may contact the Billing Department at 855-586-8160.

### Patient/Responsible Party Signature (HIPAA Policy)

X

Date