**Zohra F. Siddiqi, D.O., P.A.**

**Diplomate of American Board of Family Medicine**

# Financial Policy

Copayments, Coinsurance, deductibles and outstanding balances are expected at the time of service. You will be charged a fee of $35.00 for the inconvenience and penalty of returned checks.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to transfer all associated financial liability for the claim to the guarantor. Failure to promptly resolve the financial obligation will result in third party collection and/or legal action.

It is the patient's responsibility to inform Dr. Zohra F Siddiqi's staff of any change in name, insurance, phone number, or other important information relating to the payment. Failure to do so may result in penalty fees or nonpayment by insurance.

If you do not show up for an appointment without 24 hour notice or reschedule your appointment without a 24 hour notice you will be charged a $50.00 fee.

Guarantor/ patient

Signature: ____________________________________________

Print Name: ___________________________________________

# PATIENT INFORMATION

Today's date: ______________________ PCP: ______________________

## PATIENT INFORMATION

Patient's last name: ______________ First: ____________ Middle: _____ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: __________ Age: ______ Sex: ________ Cell Phone No.: ______________

Street address: ________________________ Social Security no.: __________ Home phone no.: __________

P.O. box: ______________ City: ______________________ State: __________ ZIP Code: __________

Occupation: ______________ Employer: ______________________________

Other family members seen here: ______________________________

## INSURANCE INFORMATION

IF YOUR NEW BORN IS UNDER YOUR INS. PLEASE PUT YOUR INFO. HERE ________________ (PLEASE GIVE OFFICE YOUR INS. CARD)

Person responsible for bill: ______________ Birth date: __ /___ /___ Address (if different): ______________________ Home phone/Cell phone: (___) ______________

Primary insurance Name : ______________________________

Member ID : ______________________________

Subscriber's name: ______________ Subscriber's S.S. no.: ______________ Birth date: ___ /__ /___ Group no.: ______________ Policy no.: ______________ Co-payment: $ ________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): ______________ Subscriber's name: ______________ Group no.: ______________ Policy no.: ______________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): ______________________ Relationship to patient: ______________ Home phone no.: (___) __________ Work phone no.: (___) __________

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 [Name of Practice] or insurance company to release any information required to process my claims.

______________________________

*Patient/Guardian signature* *Date* ______________

## Patient Information Verification

Patient Name: ______________________________

Date of Birth: ______________________________

Please provide us with the phone numbers that you would like for us to call regarding your test results. If you are unavailable, a message may be left for you to return our call.

1. ____________________ Can we leave a detailed message **Y** or **N**
2. ____________________ Can we leave a detailed message **Y** or **N**
3. ____________________ Can we leave a detailed message **Y** or **N**

Please list the person(s), if any, with whom we may discuss your medical conditions and test results.

Name: ______________________________

Phone: ______________________________

Relationship: ______________________________

Name: ______________________________

Phone: ______________________________

Relationship: ______________________________

Please be advised that we will attempt to contact you via phone or mail with all test results, whether normal or abnormal. If you have not heard from us within one (1) week for labs and x-ray studies, or within two (2) weeks for pap smears and biopsies, please contact our office at 281-724-1271

Patient (or Responsible Party) Signature: ______________________________

Date: ____________________

## Consent to Treatment

I consent to the procedures which may be performed during this outpatient visit, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, diagnostic procedures, blood and/or urine specimens for substance abuse (drug/alcohol) screenings, x-ray examination, medical or nursing treatment or other physician or clinic services rendered to me as ordered by my physician or other healthcare professional.

This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes.

**Agree**____________ **Disagree**_____________ (initials)

## Notice of Privacy Practices

I acknowledge that the medical privacy is in compliance with HIPPA regulations with regards to the ways in which the medical practice uses or discloses my healthcare information for treatment, payment, healthcare operations and others described and permitted uses and disclosures. I understand that I may reference www.hhs.gov/ocr/privacy/hippa if I have a question.

Acknowledge: _________________________ (initials)

I, as the patient, parent, guardian, spouse, guarantor or agent of the patient, certify that I have read, or have read to me, and understand this Consent to treatment. I have signed this Consent to Treatment knowingly, freely, and voluntarily. I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

Patient or Patient's Legal Representative Signature: _______________________________________

Print Name: ____________________________

Date: ________________________________

If signed by other than patient, indicate relationship: _______________________________________

***Authorized representative must submit copies of legal document supporting his or her authority to act on the patients behalf***

Witness Signature: _____________________________________

Witness Name: _______________________________________

Date: _____________________________________________