PATIENT REGISTRATION

LAST NAME	FIRST NAME	DATE OF BIRTH	MALE / FEMALE
ADDRESS		HOME PHONE #	
CITY	STATE	ZIPCODE	SS #
MARITAL STATUS	IF MARRIED SPOUSE'S NAME		
EMERGENCY PHONE # (NOT HOME NUMBER)/ NAME OF EMERGENCY CONTACT		NAME OF EMERGENCY CONTACT	
PATIENT CELL NUMBER	REFERRED BY	PRIMARY CARE PHYSICIAN	
INSURANCE INFORMATION			
NAME OF PRIMARY INSURANCE		SUBSCRIBER'S NAME	
NAME OF SECONDARY INSURANCE		SUBSCRIBER'S NAME	
BILLING INFORMATION			
BILLING NAME (IF OTHER THAN PATIENT)		RELATIONSHIP TO PATIENT	
HIS / HER SS #		HIS / HER BIRTHDATE	
ADDRESS AND PHONE # IF DIFFERENT THAN PATIENTS			

EMPLOYER (OF PATIENT) **DEPARTMENT / JOB TITLE**	EMPLOYER (OF SPOUSE)
NAME	NAME
ADDRESS	ADDRESS
CITY	CITY
PHONE #	PHONE #

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to *Dr. Maha Abboud/Dr. Terri Washington* for dependents or myself. I understand I am responsible for any deductibles, co-insurance, or amounts for services not covered by the insurance carrier. In signing this form I am authorizing *Dr. Abboud/Dr. Washington* to examine and treat me.

DATE: _____ SIGNATURE: **X**_____

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I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practices may use and disclose my confidential information.

DATE: _____ SIGNATURE: **X**_____

(If you are not the patient, please specify your relationship to the patient)

Updated: 01-01-2015

Patient Financial Policy

I understand I am responsible and I agree to the following:

- Any deductible, co-insurance or amount for services not covered by the insurance carrier.
- A cancellation **fee of $30.00** in the event I do not notify the office 24 hours in advance of canceling my appointment, I do not come in for my appointment or I cancel the appointment on the same day
- A **$5** fee on unpaid balances will be added to my account on a monthly basis. (If not paid before the due date on monthly statement)
- I agree to reimburse (Diabetes, Osteoporosis, Obesity, Inc.) fees of any **collection agency**, which may be based on a percentage at a maximum of 33% of the debt and all costs and expenses, including reasonable attorneys' fees, the office incurs in such collections efforts.
- A fee for a copy of medical records should I request them for continued care elsewhere or other purposes.

X _____ _____
Patient Signature Date

X _____ _____
Guardian Signature (if patient is a minor) Date

I, **X**_____ have received a copy of the **office policy**

And understand I will be notified if there are any changes to the policy.

X _____ _____
Patient Signature Date

X _____ _____
Guardian Signature (if patient is a minor) Date

Patient Privacy Form

I give my permission for Dr. Maha Abboud/Dr. Terri Washington to speak with the following people regarding my medical condition and treatment:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

ONLY SIGN BELOW IF YOU DO NOT authorize any information regarding your condition, medications, or tests be discussed with anyone.

_____
Patient Signature

Any messages regarding appointments, medications, or test results **MAY** be left on my answering or cell phone.

Home phone _____ Cell phone _____

I understand that this authorization is valid until revoked or changed by written notice, and will be kept with my medical records.

_____	_____
Patient Signature	Date

_____
(Parent if patient is minor)