

## 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	
<b>INSURANCE INFORMATION</b>			
NAME OF PRIMARY INSURANCE		SUBSCRIBER'S NAME	
NAME OF SECONDARY INSURANCE		SUBSCRIBER'S NAME	
<b>BILLING INFORMATION</b>			
BILLING NAME (IF OTHER THAN PATIENT)		RELATIONSHIP TO PATIENT	
HIS / HER SS #		HIS / HER BIRTHDATE	
ADDRESS AND PHONE # IF DIFFERENT THAN PATIENTS			
<b>EMPLOYER INFORMATION</b>			
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** \_\_\_\_\_

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)

**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.<sup>00</sup>** 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
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Name	Relationship	Phone
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**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)