DR. ALAMI'S KIDS

Medical Gardens Plaza
3813 22nd St. Suite E
Lubbock, TX 79410
806-792-8922
Dr. Bachar Al-Alami, MD PA
Pediatric and Adolescent Medicine

PATIENT INFORMATION: Referred by: _____ Acct#: _____ Date: _____

Last Name: _____ First Name: _____ Middle: _____

Street Address: _____ City: _____ State/Zip _____

Date of Birth: _____ Age: _____ SS# _____ Sex (M/F) _____ Home#: _____

RESPONSIBLE PARTY: _____ SS# _____ DOB: _____

Address: _____ City: _____ State/Zip _____

Home#: _____ Work #: _____ Cell#: _____ Marital Status: S M D W

Employer Name and Address: _____

Spouse Name: _____ DOB _____ Relationship to child _____ SS# _____ Sex (M/F)

Address: _____ City: _____ State/Zip _____ Work#: _____

Emergency Contact: not living with you

Name: _____ Relationship: _____ Home#: _____ Cell#: _____ Work#: _____

Circle Appropriate Pryor: Private Pay Commercial PPO/HMO BC/BS MEDICAID

Primary Insurance Co. Name: _____ Co-pay amount: $ _____

Ins Co Address: _____ Phone#: _____

Insured member: _____ Relationship to patient: _____

SS#: _____ Policy#: _____ Group#: _____

Do you have a secondary insurance? Y / N If so, please give info same as above

_____

_____

Other children:

Name: _____ Sex (M/F) DOB _____ SS# _____

Name: _____ Sex (M/F) DOB _____ SS# _____

Name: _____ Sex (M/F) DOB _____ SS# _____

Name: _____ Sex (M/F) DOB _____ SS# _____

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Assignment of **Benefits Form**

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Bachar Al-Alami for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorizeDr. Bachar Al-Alami to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain effect until revoked by me in writing.

I have requested medical services from Dr. Bachar Al-Alami on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately uponpresentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Print Patient's Name Date

Patient/Responsible Party Signature Witness

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CONSENT FOR **TREATMENT**

Dr. Al-Alami provides primary health care including the diagnosis and treatment of illness or injuries.

The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically attended and treated by either doctor.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, their assistants as necessary in the medical staff's judgment.

I understand that this consent form will be valid and remain in effect as long as I (he/she) am under the care of Dr. Al-Alami.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient

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Patient Name: _____ Date: _____

Patient Acct#: _____

INSURANCE WAIVER **ACKNOWLEDGEMENT**

Dear Patient,

Due to the rising cost ofhealthcare and the minimum reimbursement from insurance companies, you will be responsible for the charges thatre not covered by yourinsurance company. Some charges are considered, but atless than the doctor's cost, therefore, you will be responsible for the difference, all other charges not payable will be charged in full. These charges are payable at the time of service. Please sign below that you acknowledge and accept this waiver and responsibility.

_____ _____

Patient/Responsible Party Signature Date

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Acknowledgement of Review of **Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains How my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient

_____
Description of Personal Representative's Authority

Authorization to Disclose Health Information

DR. ALAMI'S KIDS

I hereby authorize the use or disclose of health information from the Medical Record of:

Patient Name: _____ Date of Birth: _____

I authorize the following Individual or Organization to disclose the above named individual's health information:

_____ Address/Fax Number _____

This information may be disclosed to and used by the following individual or organization:

_____ Address/Fax Number _____

For the purpose of: __ changing Physician __Moving __ Continue Treatment __Daycare __School __Court

Other (specify) _____

Please release the following health information:

___ Entire medical record
___Problem List
___Progress Notes from _____to _____
___History/ Physical Exam
___Medication List
___Immunization Record

___X-ray/Imaging Report from _____ to ___
___ Laboratory Results from _____to_____
___Ekg Report
___Genetic Testing Information
___Other Diagnostic reports (specify_____
___Other (Specify_____

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___ Yes, I consent to the release of this information. ___No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time.

I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information.

I understand that the revocation will not apply to information already released in response to this authorization.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:

_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact Dr. Bachar Al-Alami.

_____ Date: _____
Signature of Patient or Legal Representative

_____ _____
Relationship of p Patient (If Legal Representative) Witness

Date of Request Completed: _____ #pages copied: _____ Reviewed only: _____

Charges $_____ Cash: _____ Check: _____ Credit Card: _____

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