Hasbani & Hasbani Medical Group

Patient Registration

Patient Information

All fields in red must be filled out. If a question doesn't apply to you, please enter "NONE"

First Name ______ Last Name ______ Email ______

Preferred Name ______ Home Phone ______ Cell Phone ______

Birth Date ______ Sex ○ Female ○ Male Social Security # ______

Address 1 ______ Address 2 ______ City ______ State ______ ZIP ______

Dominant Hand ○ Right ○ Left Height ______ Weight ______ Work Phone ______

Providers

Who are you here to see? ______ Primary Care Provider ______ Referring Provider ______ Preferred Pharmacy (Name & ZIP) ______

Emergency Contact

First Name ______ Last Name ______ Phone ______ Relationship ______

Address ______ City ______ State ______ ZIP ______

Insurance

Primary Insurance

Carrier ______ Copay ______

Certificate or ID # ______ Group # ______ Claims ZIP Code ______

The claims ZIP code can be found on the back of the card.

Carrier

Copay

Certificate or ID #

Group #

Claims ZIP Code

I hereby authorize Dr. Hasbani to release any medical information necessary to the Attorney, No-Fault Insurance Carrier, and Workman's Compensation. I agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. After 3 months outstanding balances will be charged an additional 18% a year. If my account remains unpaid I agree to pay, in addition to the amount due, reasonable attorney fees and court costs if suit is initiated to collect the balance. For missed appointments, you may be responsible for the charge of the visit at the discretion of the doctor. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature

Hasbani & Hasbani Medical Group

Patient History

Instructions

All fields in red must be filled out. If a question doesn't apply to you, please enter "NONE"

Current Problems

List the reasons you are coming to see the neurologist

Current problems (issue, how long)

____

Please list all of your drug allergies

Drug allergies (and reaction)

____

Past Medical History

Please list your past medical history.

Medical history (condition, year of diagnosis, treating physician)

____

Past Surgical and Hospitalization History

Please list your past surgeries/hospitalizations.

Surgeries (type, surgeon, year): ______________

Hospitalizations (place, year, reason) ______________

Family History

Please list medical conditions associated with the following family members (please also indicate if deceased and cause of death):

Father ______________

Mother ______________

Brother ______________

Sister ______________

Son ______________

Daughter ______________

Grandfather ______________

Grandmother ______________

Other ______________

Social History

4/16

Marital Status	Education Level	Employer	Occupation

Habits

Are you currently a smoker? ◯ Yes ◯ No

If yes, how much?

Have you smoked in the past? ◯ Yes ◯ No

If yes, how much? | If yes, how many years? | If yes, when did you quit?

Do you drink alcoholic beverages? ◯ Yes ◯ No

If yes, how much?

Have you used any recreational drugs? ◯ Yes ◯ No

If yes, which ones?

Legal History

Must fill out if being seen for a personal injury or if this is a workman's compensation case

Case Type

◯ Personal Liability ◯ Workman's Compensation

Please fill out if Personal Liability / Personal Injury (i.e. car accident, slip and fall)

Leave blank unless applicable.

Date of Injury	Place of Injury	If hospitalized, where?	Driver of motor vehicle

Attorney name	Attorney phone	Attorney fax (important)

Attorney address	Attorney city	Attorney State	Attorney ZIP

No fault insurance carrier	Carrier phone

Carrier address	Carrier city	Carrier state	Carrier ZIP

Claim # | Insured name

Please fill out if Workman's Compensation

Leave blank unless applicable.

Employer responsible for injury

Employer address | Employer city | Employer state | Employer ZIP

Date of injury | Claim # | Compensation carrier (Ins. Co.)

Carrier address | Carrier city | Carrier state | Carrier ZIP

Diet and Exercise History

Diet | Exercise

Please record any changes to your weight in the last year.

Weight Loss | Weight Gain

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Review of Systems

Ophth

	Yes	No
Loss of vision	○	○
Double vision	○	○

GU

	Yes	No
Bladder accidents	○	○
Impotence	○	○

ENT

	Yes	No
Hearing loss	○	○
Ringing in ears	○	○
Persistent dizziness	○	○
Difficulty swallowing	○	○

Endo

	Yes	No
Thyroid disease	○	○
Diabetes	○	○

If yes to diabetes, how long?

____

Musk

	Yes	No
Neck pain	○	○
Low back pain	○	○

CV

	Yes	No
Chest pain	○	○

Palpitations	O	O
Light headedness	O	O
High blood pressure	O	O

If high blood pressure, how long?

____

Heme

	Yes	No
Easy bruising/bleeding	O	O
Blood clots in legs or lungs	O	O
Miscarriage	O	O

Psych

	Yes	No
Depression	O	O
Anxiety	O	O
Psychiatric illness treatment	O	O

Resp

	Yes	No
Difficulty breathing	O	O
Asthma	O	O

GI

	Yes	No
Persistent diarrhea	O	O
Bowel accidents	O	O
Hepatitis A	O	O
Hepatitis B	O	O
Hepatitis C	O	O

Neuro

	Yes	No

Strokes	O	O
Headaches	O	O
Seizures	O	O
Tuberculosis	O	O

Const

	Yes	No
Persistent fevers	O	O

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Current Medications

Please list all of the medications you are taking now.

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

Medication	Dose	How Often?	Date Started?

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Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES To all our patients: A law has been passed requiring us to let you know your rights. We do not intend to bore you, but are required to have you review and sign an acknowledgment that you received this information.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice of Privacy Practices describes the ways in which we may use and disclose medical information about you. In this notice, we refer to this medical information as your protected health information (PHI). Protected health information is information about you, including demographic information that may identify you and that relates to your present, past or future physical or mental health and related health care services. This notice also describes your right and the practice obligations with respect to the use and disclosure of your protected health information.

We are required by law to:

Maintain the privacy of your protected health information

Provide our patients with this notice of our legal duties and privacy practices with respect to your protected health information

Abide by the terms of this notice, as currently in effect.

We understand that your protected health information is personal, and we are committed to protecting this information. In order to provide you with quality care and to comply with certain legal requirements, we create records of the care and services you receive from us. This notice of privacy practices applies to these records and other communications whether verbal or in writing about your PHI

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. This notice will contain the effective date on the first page.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

A. Uses and disclosures of your Protected Health Information for Payment, Treatment and Healthcare Operations

This practice may use and disclose your protected health information as described in this section in the context of providing you with treatment and services, obtaining payment for that treatment and maintain our healthcare operations. The paragraphs below describe these categories and the different ways that we may use and disclose your protected health information within each category. For most categories, we provide an example of one of the uses or disclosures. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our practice.

For Treatment: We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians or other personnel or third parties who are involved in taking care or you. For example, we will share you PHI with a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Different members of our workforce also may share your PHI in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may also disclose your PHI to people outside our practice who may be involved in medical care, such as family members or others we use to provide services that are part of your care such as a Visiting Nurse.

For Payment: We may use and disclose your PHI so that the treatment and services we provide may be billed and payment collect from you, an Insurance company or a third party. For example, we may need to give information about your treatment to your health insurance provider so that it can pay us or reimburse you. We may also inform your health insurance provider about treatment that we intend to provide so that we can obtain any necessary approval or to confirm coverage for treatment such as anticipated hospitalizations or imaging (MRI's, X-rays, etc.)

For Health Care Operations: We may use and disclose your PHI as necessary to support the business operations and activities of our practice. These uses, and disclosures are necessary to run the practice and make sure that all of our patients receive quality care. For example, we may use your medical information to review our treatment and services to evaluate the performance of our staff. We may also disclose information to doctors, nurses, technicians, medical students

and other personnel for educational purposes. We may call you by name while you are in our waiting room when the physician is ready to see you.

Incidental Disclosures: In the course of making disclosures of your PHI for the purposes of treatment, payment and healthcare operations, we may also, as a by-product of these disclosures, make incidental disclosures. We will take reasonable safeguards to minimize the incidental disclosures.

Appointment Reminders: We may use and disclose medical information, as necessary, to contact you as a reminder that you have an appointment for treatment or medical care.

B. Uses and Disclosure of Your Protected Health Information Based upon Your Authorization

All other uses and disclosures of your PHI will be made only with your specific authorization in writing, unless otherwise permitted by law or listed below. Some examples of circumstance in which we will be required to obtain authorization will be to use your PHI for marketing or to provide you with treatment in the context of a research study. You may revoke your authorization at any time, in writing, except that this revocation will not be effective to the extent that we have already relied on your authorization or, where the authorization relates to research study, the continued use and disclosure of your PHI is necessary to maintain the integrity of the research study.

C. Uses and Disclosure of Your Protected Health Information After Providing You with an Opportunity to Object

Individuals Involved In Your Care or Payment for Your Care: We may release your PHI to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also inform your family or friend about your condition.

D. Uses and Disclosure of Your Protected Health Information That May be Made Without Your Authorization or Opportunity to Object

Under certain circumstances, we may use or disclose your PHI without obtaining your authorization or without providing you with an opportunity to object. These situations include the following: **As Required by Law:** We will disclose your PHI when required to do so by federal, state or local law.

This is to certify that I have received and had an opportunity to review the Notice of Privacy Practices.

Signature

Hasbani & Hasbani Medical Group

Authorizations

Communication Policy

We will telephone you at your home. If you're not available we will leave a message on your answering machine or with whoever answers the phone. In case of an urgent matter, we will also attempt to reach you on your cell phone or at work. We routinely contact our patients by telephone for a variety of reasons;

- Appointment scheduling
- Appointment reminders
- Routine test results
- Procedure preparation and instructions
- Response to your questions or concerns

Your signature indicates you agree with our communication policy.

Signature

____

Authorization to request medical information on my behalf

Please list those who you'd like to authorize to request medical information on your behalf

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

The people listed above have permission to be informed of scheduling, procedures, test results, and my medical condition.

Signature

____

Hasbani & Hasbani Medical Group

Payment Policy and Financial Agreement

Thank you for choosing M. Hasbani MD & M.J. Hasbani MD/PhD.

Please review the following Payment Policy and Financial Agreement as it applies to being a patient in our practice. We believe that part of excellent healthcare is to establish and communicate to our patients the financial policy of our practice up front and at the time of service.

Co-Pays and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. We accept most forms of payment including; credit cards, debit cards, HSA cards, checks and cash. When billing your insurance company for a claim, we require that either a credit/debit or HSA card be on file with our practice. All financial and credit card information is stored offsite by our 3rd party provider Inbox Health Corp and in a secure and encrypted PCI/HIPPA compliant environment. All balances are to be paid in full at the time of service or require a payment plan to be set up at the time of service. Any bill or pre-arranged payment play that is not paid within 10 days or the agreed upon terms may be subject to collections and late charges. Our staff is available to set up payment plans for larger balances upon request. We understand and share your concern regarding medical costs and have designed our billing practices to specifically help you to afford your medical care.

Nonpayment: If you account becomes past due, you will receive a final notice stating that your account may now be sent to collections if payment is not made. This notice may also be referred to a collections attorney and could affect your credit rating. We will always work with you as our patient to assist you with a financial plan for your out of pocket medical expenses, but it is very important that you communicate and discuss your financial situation with us up front as it pertains to the payment of your bill.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at the time of your visit. If you are insured by a plan we accept and have a Co-Insurance or Deductible obligation that has not yet been met, payment is required in full and until we can verify your responsibility has been met. Please contact your insurance company with any questions you may have regarding your coverage or the status of your deductible. Some insurance plans such as PPO's or if you are "out of network" will send the physicians payment as a reimbursement directly to you as the patient. If you have this type of insurance plan, you must make payment in full at the time of service.

Non-covered services: Please be aware that some ~ and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare, or other insurers. You must pay for thesis services at the time of your visit and in the event that a claim is not accepted or paid for by the insurance provider.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor We must obtain a copy of your valid driver's license or photo ID in addition to your current valid insurance card. If you fail to provide us with correct insurance information you will be responsible for any and all balances or claims as a result.

Claim and Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contact between you and your insurance company we are not party to that contract.

Coverage Changes: If you insurance changes please notify us so we can make the appropriate changes to help you receive your maximum benefits upon future visits. If your insurance company doesn to pay your claim because of a change or lapse in insurance any balance will automatically be billed to you.

Appointment Cancellation / No Show Policy: We understand that there are times when you must miss and appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment in not cancelled at least 24 hours in advance you will be charged up to a hundred dollar ($100) fee: this is not covered by your insurance company.

Financial agreement: I understand that all costs associated with my care and/or the care of anyone that I am the responsible party/guarantor for will be my full financial responsibility in the event that my insurance does not cover a service billed for by this office I understand that I am fully responsible for the payment of theses costs within 10 days of being notified by

the practice. In the event that my account is turned over to a collection agency I acknowledge that I will be responsible for the full cost of all interest, attorneys fees and collection costs associated with the amount due.

I authorize M. Hasbani MD & M.J. Hasbani MD/PhD to release any information needed to determine insurance benefits payable for related services. I hereby acknowledge that M. Hasbani MD & M.J. Hasbani MD/PhD have offered me a copy of their Notice of Privacy that describes how information will be used and disclosed. M Hasbani MD & M.J. Hasbani MD/PhD has the right to modify the privacy practices as outlined in the Notice to keep current with regulation.

I hereby authorize the practice of M Hasbani MD & M.J. Hasbani MD/PhD to automatically charge my credit/debit or HSA card for any balance this is owed after insurance reimbursement or in the case of being denied by my insurance provider. This authorization is valid without any additional consent on my part up to an amount of $250.00. For amounts and balances over

Signature of Patient/Responsible Party