SELECT
INTERNAL MEDICINE &
PEDIATRICS

New Patient Registration Form

Date: _____
Patient Name: (Last) _____ (First) _____ (Middle) _____
DOB: _____ Marital Status: ____single ____ married ____ divorced ____ separated ____ widower
Gender: _____ Language: _____ Interpreter needed? ___ Yes ___ No
Race: _____ Ethnicity: _____ Email: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Primary Ph#: _____ Secondary Ph#: _____
May we leave a detailed voice message? ___ Yes ___ No
Pharmacy Name: _____ Pharmacy Ph#: _____
How did you hear about us? _____

Insurance Information (please give your insurance card and ID to the receptionist)
Person responsible for the bill: _____ DOB: _____
Primary Ph#: _____ Secondary Ph#: _____
Address if different from patient: _____
_____
Employer Name: _____

Primary Insurance		Secondary Insurance	
Name of Insurance:		Name of Insurance:	
Subscriber Name:		Subscriber Name:	
Relationship to subscriber:		Relationship to subscriber:	
Subscriber SSN:	DOB:	Subscriber SSN:	DOB:
Policy #:	Group #:	Policy #:	Group #:

In Case of Emergency
Name of local friend or relative (not living with you): _____
Relationship: _____ Phone#: _____

The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian signature: _____ Date: _____

Relationship to patient: _____

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Consent to Treat

Please initial to confirm that you have read and understand each section

_____ I give permission for Select Internal Medicine & Pediatrics to give me medical treatment.

_____ I allow Select Internal Medicine & Pediatrics to file for insurance benefits to pay for the care I receive.

_____ I understand that:

- Select Internal Medicine & Pediatrics will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

_____ I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_____ _____

Signature **Date**

_____ _____

Printed Name **Relationship to patient**

Authorizations and Assignments

Thank you for choosing Select Internal Medicine & Pediatrics. We are happy that you have chosen us for your healthcare needs. Please review our office policies listed below. You are welcome to call our office anytime during business hours should you have questions or concerns.

Office Policies

Our provider participates with many medical health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check-In

Please be prepared to submit the following documents when check-in for each visit. These documents will be scanned and saved as part of your patient record.

- ☐ Current Insurance Card
- ☐ Current Photo Identification
- ☐ Update contact information

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit once verification has been obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services rendered.

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Please initial to confirm that you have read and understand each section

_____ **Payment of Patient Responsibility**
Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, coinsurance and any past due amounts applicable for each visit and/or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits.

_____ **Non-Covered Services**
Please be aware certain office procedures or services may not be covered or may be considered "not medically necessary," "experimental" or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know your benefits and limitations or your current health care coverage. This clinic will provide medically necessary care based on a patient's medical needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plan's specific benefits and coverage limitations.

_____ **NSF Checks/Denied Credit Card Payments**
You will be charged a $25.00 fee should a payment be returned for insufficient funds. The fee applies to payments made at our front desk, mailed in, electronically through the internet or payments made by phone.

_____ **Past Due Amounts**
In the event that your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

_____ **Additional Services Rendered During a Preventative Screening**
Please be aware if there are medical issues that you would like to discuss with the doctor that fall outside of an annual preventative visit, you will be scheduled for a problem visit instead and will need to reschedule the annual preventive visit.

_____ **Third Party Insurances**
We do not file insurance claims to non-contracted Third Parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the time of service and file the claim with your insurance company. An itemized statement may be obtained by calling our office. This statement will assist you in reimbursement. It is your responsibility to file claims in these instances.

_____ **Appointment Scheduling**
You will receive courtesy reminders from the office of your appointment date and time. If you are unable to keep your appointment, please contact us as soon as possible. Repeated failure to call and cancel your scheduled appointment without notice could result in your dismissal from the practice. You may be worked back into the schedule at the discretion of staff should you arrive 10 or more minutes late. However, there will not be a charge should you wish to reschedule the appointment instead.

_____ **Forms/Medical Records**
Forms and medical letters can be completed upon request. The cost is $25.00 and is collected upon receipt/release of document.

_____ **Medical Records**
Requests for your medical records must be in writing via a medical records release form. The cost is 25.00 for the first 20 pages and $.50 for each additional page.

_____ **Medication Refills**
Medication refill requests should be made at least 1 week prior to running out of medication to avoid lapses. We cannot guarantee that a medication will be approved if requested without adequate notice.

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Authorization to Release Information

I hereby authorize Select Internal Medicine & Pediatrics to (1) release any information necessary to insurance carriers regarding any illness and treatments; (2) process insurance claims generated in the course of an examination or treatment and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carriers including Medicare, Medicaid, private insurance and and other health/medical plan, to issue payment check(s) directly to Select Internal Medicine & Pediatrics 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.

Financial Responsibility

I acknowledge that I have requested medical services from Select Internal Medicine & Pediatrics 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 agree to pay Select Internal Medicine & Pediatrics for all services and products administered. If I participate in a managed care plan, I promise to pay for any services or products administered that are not covered under the plan, were not certified by the plan as medically necessary or were denied by the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges. I further understand that fees are due and payable on the date of services rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as original.

Authorization and Assignment Acknowledgement: My signature certifies I have read and understand the above content of this document.

_____ _____
Printed Patient Name **Patient Date of Birth**

_____ _____
Signature **Date**

_____
Relationship to patient

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 I am entitled to receive a copy of this document.

_____ _____
Printed Patient Name **Patient Date of Birth**

_____ _____
Signature **Date**

_____
Relationship to patient

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Designation of Personal Representatives

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) that became effective on April 14th, 2003, health care providers and their staff are limited in the information that they may share with individuals other than the patient or his/her guardian. In many cases, patients would like to involve a member of their family or another person in the management of their healthcare. Such disclosures of information are permitted by HIPAA when the patient (or his/her parent or guardian) designates one or more individuals as his/her personal representative. Therefore, if you would like to designate one or more individuals to serve as your personal representative, please complete the information below.

Name of patient: _____ Date: _____

I, the patient/guardian, hereby designate the individual(s) or the Personal Representative listed below to receive information pertaining to my health care (including appointments, diagnoses, treatment plans, insurance information and other related topics). This designation will remain in effect until such time as I revoke in writing.

Name of Personal Representative	Relationship	Phone Number	Address

_____ _____
Signature of Patient/Guardian Date

_____
Relationship to Patient

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Authorization to Release Healthcare Information

Patient Name: _____ DOB: _____

I request and authorize:

Doctor's/Clinic Name: _____
Address: _____
_____

Phone #: _____
Fax #: _____

To release healthcare information of the patient named above to:

Dr. Co-May Pasdar-Shirazi, MD
Select Internal Medicine & Pediatrics
7619 Branford Place Suite 210
Sugar Land, TX 77479
Phone: (832) 492-4467
Fax: (833) 471-3162

☐ Healthcare information relating to the following treatment, condition or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient/Guardian Signature: _____

Date: _____

* This authorization expires ninety days after it is signed *