8.2-MTBC-F-07

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CONFIDENTIAL

Mehnaz A. Haq, MD, LLC

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient

◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ____/____/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (_____) _____-_____

CELL PHONE: (_____) _____-_____

PATIENT'S NAME: _____ , _____ _____

LAST *FIRST* *MI*

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SSN: _____ - _____ - _____ **GENDER** ◯ *M* ◯ *F* **BIRTH-DATE:** _____/_____/_____ ◯ *SINGLE* ◯ *MARRIED* ◯ *DIVORCED* ◯ *SEPARATED* ◯ *WIDOWED*

Patient Employed By : _____

Business Address: _____

Occupation: _____ **Business Phone:** (_____) _____-_____

Name of Spouse/Responsible Party (If Patient is minor): _____ , _____ _____

LAST *FIRST* *MI*

Spouse/Responsible Party Employed by: _____

Business Address: _____

Occupation: _____ **Business Phone:** (_____) _____-_____

RESPONSIBLE PARTY/SPOUSE SSN : _____ - _____ - _____

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : _____ **ID #:** _____ **GRP #:** _____

*SUBSCRIBER'S NAME: _____ *BIRTH DATE: _____/_____/_____

ADDRESS OF PRI. INS. : _____

NAME OF SEC. INS. : _____ ID #: _____ **GRP #:** _____

*SUBSCRIBER'S NAME: _____ *BIRTH DATE: _____/_____/_____

ADDRESS OF SEC. INS. : _____

***Required by HIPAA**

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PIH _____ Relationship _____

PHONE: (_____) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to **Mehnaz A. Haq, MD, LLC** all benefits, if any, otherwise payable to

(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Mehnaz A. Haq, MD, LLC**

(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

_____ _____

(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, MEHNAZ A.HAQ, MD, LLC's office originates and maintains papers and /or electronic records describing my health history, symptoms and examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can testify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of the healthcare professionals.

I understand and have been provided with *Notice of Information Practices* that provides a more complete description of information uses and disclosures.
I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restriction as to how my health information my be used or disclosed to carry out treatment, payment or healthcare operation

I understand that MEHNAZ A. HAQ, MD, LLC.'s office is not required to agree to the restriction requested. I understand that I am revoking this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand the MEHNAZ A. HAQ, MD, LLC.'s office reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should MEHNAZ A. HAQ, MD, LLC.'s office change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent

_____ _____
Patient's Signature Date

Who else do you give authorization to receive your medical information?
Name _____ D.O.B: _____
Relationship: _____
Address:_____
Tel: _____

FOR OFFICE USE ONLY
[ ] Consent received by _____ o n _____ .
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

HEALTH HISTORY
(CONFIDENTIAL)

Name _____ Gender ◯ M ◯ F Date Of Birth ____ /___/_____

Date of last physical examination:_____ Reason for this visit: _____

Pharmacy : _____ Tel: _____

SYMPTOMS: Check (x) symptoms you currently have or have had in the past year

General	Gastrointestinal	Eye, Ear, Nose, Throat	MEN only
_Chills	_Appetite Poor	_Bleeding Gums	_Breast Lump
_Depression	_Bloating	_Blurred Vision	_Erection Difficulties
_Dizziness	_Bowel Changes	_Crossed Eyes	_Lump in Testicles
_Fainting	_Constipation	_Difficulty Swallowing	_Penis Discharge
_Fever	_Diarrhea	_Double Vision	_Sore on Penis
_Forgetfulness	_Excessive Hunger	_Earache	_Other
_Headache	_Excessive thirst	_Ear Discharge	**WOMEN only**
_Loss of Sleep	_Gas	_Hay Fever	_Abnormal Pap Smear
_Loss of Weight	_Hemorrhoids	_Hoarseness	_Bleeding Between Periods
_Nervousness	_Indigestion	_Loss of Hearing	_Breast Lump
_Numbness	_Nausea	_Nosebleeds	_Extreme Menstrual Pain
_Sweats	_Rectal Bleeding	_ Persistent Cough	_Hot Flashes
Muscle/Joint/Bone	_Stomach Pain	_Ringing in Ears	_Nipple Discharge
Pain,weakness,numbness in:	_Vomiting	_Sinus Problems	_Painful Intercourse
_ Arms	_Vomiting Blood	_Vision - Flashes	_Vaginal Discharge
_Back _ Legs	**_Cardiovascular**	_Vision - Halos	Other
_Feet _ Neck	_Chest Pain	**Skin**	_LMP Date _____
_Hands _ Shoulders	_High Blood Pressure	_Bruise Easily	_Date of last Pap Smear _____
Genito-Urinary	_Irregular Heart Beat	_Hives	_Have You Had A
_Blood in Urine	_Low Blood Pressure	_Itching	_Mammogram?_____
_Frequent Urination	_Poor Circulation	_Change in Moles	_Are You Pregnant? _____
_Lack of Bladder Control	_Rapid Heart Beat	_Rash	_Number of Children _____
_Painful Urination	_Swelling of Ankles	_Scars	
	_Varicose Veins	_Sore that won't heal	

CONDITIONS: Check (x) conditions you now have or have had in the past.

_Aids	_Chemical Dependency	_High Cholesterol	_Prostate Problem
_Alcoholism	_Chicken Pox	_HTV Positive	_Psychiatric Care
_Anemia	_Diabetes	_Kidney Disease	_Rheumatic Fever
_Anorexia	_Emphysema	_Liver Disease	_Scarlet Fever
_Appendicitis	_Epilepsy	_Measles	_Stroke
_Arthritis	_Glaucoma	_Migraine Headaches	_Suicide Attempt
_Asthma	_Goiter	_Miscarriage	_Thyroid Problems
_Bleeding Disorders	_Gonorrhea	_Mononucleosis	_Tonsillitis
_Breast Lump	_Gout	_Multiple Sclerosis	_Tuberculosis
_Bronchitis	_Heart Disease	_Mumps	_Typhoid Fever
_Bulimia	_Hepatitis	_Pacemaker	_Ulcers
_Cancer	_Hernia	_Pneumonia	_Vaginal Infections
_Cataracts	_Herpes	_Polio	_Venereal Disease

ALLERGIES TO MEDICATIONS or Substances _____

_____

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	If deceased, age at death?	If deceased, cause of death?	Check (x) if your blood relatives had any of the following:		
						Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS/Serious Illness/Injuries			**PREGNANCY HISTORY**		
Year	**Hospital**	**Reason and Outcome**	**Year of Birth**	**Gender of Child**	**Complication if any**

Have you ever had a blood transfusion? __ Yes __ No If yes, please give approximate dates:			**Health Habits Check (x) which substances you use and describe how much you use.**		
List of Medications	**Mg**	**Quantity**		Caffeine	
				Tobacco	
				Drugs	
				Alcohol	
				Other	
			Occupational Concerns Check (x) if your work exposes you to the following:		
				Stress	
				Hazardous Substances	
				Heavy Lifting	
				Other	

Your occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

THE OFFICE OF
MEHNAZ A. HAQ, MD, LLC

FINANCIAL POLICY

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: In certain rare circumstances - and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.)

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts cash or personal checks, but we do not accept credit cards. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of Thirty-Five Dollars ($35), which shall be due and owing immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at

the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail. Your failure to cancel an appointment in a timely manner (i.e., at least 24 hours prior to the visit) deprives other patients of an opportunity to visit our office. You will be responsible for a paying a missed appointment fee of Twenty-Five Dollars ($25) if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. We recognize the fact that there may be circumstances which may not permit you to give us 24 hours prior notice but such circumstances are exceptional and extremely infrequent and shall be considered on a case to case basis.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with New Jersey law, we charge a photocopying fee of One Dollar ($1) per page, with a minimum fee of Ten Dollars ($10) and have up to thirty (30) days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

MISCELLANEOUS FEES

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

_____

Signature of Patient or Responsible Party

_____

Print Name of Patient and Responsible Party (if any)

_____

Date