



General Information Form

Raza Pasha, MD

12121 Richmond Ave, Ste 304
Houston, Texas, 77082

281-920-5558
281-920-5568 (fax)

Personal Information

Name: _____
Last First MI

Address: _____
Street

City State Zip

Social Security #: _____ - _____ - _____

Age: _____ Date of Birth: ____ / ____ / ____ Sex: Male Female

Marital Status: Single Married Separated Divorced Widowed

Home Phone: _____

Mobile Phone: _____

Employer: _____

Mobile Phone: _____

In Case of Emergency Notify: _____

Emergency Phone: _____

Referring/Primary Physician: _____

Physician's Phone: _____

Parent/Legal Guardian Information

Social Security #: _____ - _____ - _____

Name: _____
Last First MI

Address: _____
Street

City State Zip

Driver's License #: _____

Age: _____ Date of Birth: ____ / ____ / ____ Sex: Male Female

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Relationship: Mother Father Guardian Spouse
Other: _____

Primary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

Subscriber's Name: _____

Subscriber's Social Security #: _____ - _____ - _____

Relationship: Self Parent Guardian Spouse Other: _____

Subscriber's DOB: ____ / ____ / ____

Subscriber's Effective Date: ____ / ____ / ____

Policy Number: _____

Group Number: _____

Subscriber's Employer: _____

Employer's Address: _____
Street

City State Zip

Employer's Phone #: _____

Secondary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

Start Date: ____ / ____ / ____

Policy Number: _____

Group Number: _____

Subscriber's Employer: _____

Employer's Address: _____
Street

City State Zip

Employer's Phone #: _____

RECEPTIONIST WILL REQUIRE A COPY OF YOUR INSURANCE CARDS AND PICTURE ID



Consent and Disclosures Form

Raza Pasha, MD

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The following two pages outlines our billing policies, authorization for treatment, assignment of benefits, release of medical information, and our privacy policies to comply with the Health Insurance Portability and Accountability Act (HIPPA).

Billing

- I (patient, parent, or legal guardian) understand that if the current insurance information is not received at the time of service, I will be responsible for full payments at the time of services are rendered.
- If I am a self-pay patient, I am financially responsible for all services received and that payment is expected at time service is rendered.
- In the situation of third part financial responsibility to cover the cost of your visit, the primary and ultimate responsibility for payment rests with you (patient, parent, or legal guardian).
- Fees are based on the medical condition. The federal CPT code guidelines establish a complicated range of categories for office visits based on a number of factors.
- We are contracted with a number of managed care plans (**Preferred Provider Organizations, Health Maintenance Organizations, and Independent Physician Associations**). We must follow the terms of these plans including their financial relationships and **mandatory co-payments and deductibles**, which are required at time service is rendered.
- In regards to federal programs (Medicare and Texas Medicaid), we have agreed to accept as full payment the government's discounted payment schedule. You are responsible for any **mandatory co-payments and deductibles** at the time of service (although you may have supplemental co-insurance which may cover the co-payment).

Signature of Patient/Parent/Legal Guardian

____ - ____ - 200__
Date

Authorization for Treatment

I hereby voluntarily consent to medical care for the above names patient encompassing diagnostic procedures and medical treatment by the physician, his/her assistants, or designees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Signature of Patient/Parent/Legal Guardian

____ - ____ - 200__
Date

Assignment of Benefits

I hereby assign to Raza Pasha, MD, PA or Raza Pasha, MD all rights, title, and interests in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance.

Signature of Patient/Parent/Legal Guardian

____ - ____ - 200__
Date

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act (“HIPPA”) is a program allows significant rights to understand and control how your health information is used. “HIPPA” provides penalties that misuse personal health information. The following describes how we may use your information.

I authorize Raza Pasha, MD, PA or Raza Pasha, MD to use and disclose personal medical information for each of the following purposes: treatment (i.e., among health care providers), payment (i.e. insurance companies), and health care operations (i.e. internal quality control). Dr. Pasha may release medical information to the insurance carrier, Social Security Administration, third party administrators, referring physician, or any party that may be liable for all or part of medical charges information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during this period of care. Dr. Pasha may also create and distribute de-identified health information by removing identifiable information. Any other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing, except to the extent that we have already taken actions relying on your authorization.

I authorize Raza Pasha, MD, PA to release information to our selected medical institutions and hospitals for laboratory, audiological, radiological, surgical, allergic, or other ancillary medical services as may be necessary for the purpose of scheduling, billing, or determination of benefits available to the patient for the services rendered during this period of care.

- We may contact you to provide appointment reminders or health-related benefits that may be of interest to you.
- I understand that the requester may not further use or disclose the medical information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.
- I understand that I have a right to inspect or receive a copy of this authorization, an account of disclosures of my health information, or my personal health information upon my request.
- I understand that billing statements and correspondence from our office will be sent to the address listed on the previous page.
- I understand that confidential messages (i.e. appointment reminders) may be left on your home answering machine or voice mail at the phone numbers listed on the previous page (home, work, or mobile phone numbers) unless you request us not to.
- I understand that diagnosis or treatment of me by Raza Pasha, MD may be conditioned upon my consent as evidenced by my signature on this document.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, including those related to disclosures to family members, other relatives, friends, or anyone identified by you. Raza Pasha, MD is not required to agree to the restrictions that I may request. However, if Raza Pasha, MD agrees to a restriction that I request, the restriction is binding on Raza Pasha, MD, PA and Raza Pasha, MD.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Raza Pasha, MD or Raza Pasha, MD, PA has taken action in reliance on this consent.
- I understand I have a right to review Raza Pasha, MD, PA's Notice of Privacy Practices prior to signing this document. The Raza Pasha, MD, PA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Raza Pasha, MD, PA.
- Raza Pasha, MD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
- This authorization shall become effective immediately and shall remain in effect for 2 years.
- I understand that you have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint to our office, the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I also authorize the following relatives, friends, or other people that may be informed about my general medical condition or diagnosis:

Name: _____ Name: _____

Name: _____ Name: _____

Signature of Patient/Parent/Legal Guardian

_____-_____-200_____
Date