

Durrani M.D. & Associates, P.A.

Patient Information Form
(Please print)

Today's Date: _____

Referred by: _____

The requested information is essential to the doctor in his management of your condition and will be kept in the safest of confidence. Please answer all questions on both sides of form as complete as possible.

Patient Name: _____
(First) (Middle) (Last)

Current address: _____
(# and street) (Apt #) (City and state) (Zip code)

Phone: () _____ Alternate phone/cell#: _____ Work #: _____

Date of birth: _____ Age: _____ Male / Female _____ Height: _____ Weight: _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Social security #: _____ Drivers license/ ID # _____

Emergency contact: _____ Phone #: _____

Employer: _____ Work Phone# : _____

Employer address: _____

Name of insured (card holder) _____

Rel: mother, father, child, brother, sister, grandparent, caregiver, friend, self, other

If the insured is someone other than the patient please complete the following:

Insured's DOB: _____ Insured's Social security #: _____

Insured's Employer: _____ Phone #: _____

Insured's address: _____

Primary Insurance: _____
(Insurance company name) (Insurance ph #)

Secondary Insurance: _____
(Insurance company name) (Insurance ph #)

PLEASE COMPLETE THE BACK OF THIS FORM AND SIGN AND DATE

Patient History

Previous medical illnesses and surgeries that you have been hospitalized for: (date/hospital)

Date: _____ Hospital: _____ Reason: _____

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Date: _____ Hospital: _____ Reason: _____

Medication allergies: _____ **Iodine Yes/No**

Do you take ASPIRIN daily? (Yes/No) **What strength?** _____ **Plavix** (Yes/No)

Current medications being taken now? : _____

Do you have any of the following?

High blood pressure **Heart disease** **Kidney disease**

Diabetes **History of heart attack** **History of prostate cancer**

AIDS/HIV **sexually transmitted disease** **Cancer** **Fainting/Seizures**

List any serious illnesses in your immediate family (ex: diabetes, cancer, kidney disease)

Social History:

Do you smoke? Yes _____ No _____ If yes, how much? _____

Do you drink? Yes _____ No _____ If yes, how much _____

Any other pain or irritation:

Abdomen: Y/N Burning: Y/N Incontinence (cannot urinate): Y/N Back pain: Y/N

Diabetes: Y/N Kidney stones: Y/N Prostatitis: Y/N Fever: Y/N Elev. PSA: Y/N

What is the main reason for our visit today? _____

When did you first notice the problem? _____

Does anything help or make the problem worse? _____

On a scale from 1-10, with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

If you have pain, please describe (ex: sharp, dull, constant, comes and goes) _____

Is anything else occurring at the same time? (ex: fever, nausea, rash, chills) _____

How long the problem/pain does lasts? _____ Does it interfere you're your normal functions? Yes/ No

If yes, please

explain: _____

I certify that I have answered the above questions accurately and to the best of my knowledge.

Signature of patient (or of minor)

Date

Consent and Disclosure Form

THE FOLLOWING OUTLINES OUR BILLING POLICIES, AUTHORIZATION FOR TREATMENT ASSIGNMENT OF BENEFITS, RELEASE OF MEDICAL INFORMATION, AND OUR PRIVACY POLICIES TO COMPLY WITH THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT.

BILLING

- I (patient, parent or legal guardian) understand that if the current insurance information not received at the time of service, I will be responsible for the full payment at the time services are rendered.
- If I am a self-pay patient, I am financially responsible for all services rendered and that payment is expected at the time services are rendered.
- In the situation of third party 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 established 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 other insurance plans). We must follow the terms of these plans including their financial relationships and mandatory co-payments and deductibles which are required at the time services are rendered.
- In regards to federal programs (Medicare/Medicaid), we have agreed to accept as full payments the governments' 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).
- There will be a \$ 10.00 charge for completion of all forms i.e. (insurance, disability, FMLA or otherwise).

Authorization for Treatment

I hereby voluntarily consent to medical care for the below named 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 examinations.

Assignment of Benefits

I hereby assign Omar Durrani, M.D., all rights, title and interests in the benefit payable to me by an insurance policy (ies) or benefit plan under which I am covered for services rendered by the physician. I understand that if my insurance has not paid within a timely period required by law, I may be required to pay the amount in full. I realize that failure to keep this account current may result in the physician being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Confidentiality

Can confidential messages be left on your telephone answering machine or voicemail? Yes _____
No _____

Are there any restrictions on family members who we may inform about general medical condition, diagnosis, and/or treatment? Yes _____ No _____

If you answered yes, please indicate any family members you wish **not** to be informed of any of the above.

SIGNATURE

PRINTED NAME

DATE

Omar Durrani, M.D.
Durrani MD & Associates, PA
Notice of Privacy Practices

This notice describes how healthcare information about you may be used and disclosed and how you can get access to this information.

Please review carefully!

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information.

We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **12/01/02** and will remain in effect until further notice.

We reserve the right to change our privacy practices and applicable law permits the terms of this notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about notice of privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment: We may use or disclose health information to a physician or other healthcare provider providing treatment to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operations, you may give in written authorization to use your health information or to disclose it to anyone for any purpose. If you give us in written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your family and friends: We must disclose your health information to you as described in the patients' rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Service: We will not use your health information for marketing communications, without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). We may use or disclose your health information in faxing or writing, school and work medical excuses.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not **before April 2003**. If you request this accounting more than that once in a **12 month period**, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We agree **not** required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

OMAR DURRANI., M.D.

I, _____, have received and reviewed a copy of Omar Durrani's health information privacy policies and procedure.

Patient Signature

Date

Witness or Privacy Officer

If you were in the hospital recently, we will need to request records from that hospital, please fill out the information below:

Authorization for Release of Patient Information To:

I hereby authorize _____ to release records on:

Patient Name _____ D.O.B: _____

S.S.N.: _____

Release Patient Information to the Office of:

Omar Durrani, M.D.
12121 Richmond Ave. Suite 220
Houston, TX 77082
281-589-7175/Fax 281-589-7903

Records may be faxed Records may not be faxed Please mail records All records

Release the following records: _____

Purpose of release: _____

This authorization is valid for a period of six years from the date signed by the patient or legal representative unless written notice to revoke this authorization, from the patient or legal representative are received.

Print Name of Patient

Date of Request

Signature of Patient

Signature of Parent or Legal Guardian

Signature of Witness