AUSTIN SOUTHWEST OB/GYN

Welcome to Dr. Asfouri's office

DATE:_____ SS #:_____

NAME:_____ D.O.B:_____ AGE:_____
Last First MI

ADDRESS:_____ APT#_____

CITY:_____ STATE:_____ ZIP:_____

HOME#_____ CELL#_____

EMAIL ADDRESS:_____

LAB RESULTS WILL BE SENT BY TEXT OR EMAIL. PLEASE CHOOSE
_____TEXT _____EMAIL

PRIMARY INSURANCE INFORMATION:

INSURANCE CARRIER:_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S D.O.B:_____

SUBSCRIBER ID#:_____ GROUP#:_____

RELATIONSHIP TO SUBSCRIBER: SELF / SPOUSE / CHILD

SECONDARY INSURANCE INFORMATION (if applicable):

INSURANCE NAME:_____ ID#_____ GROUP#:_____

SUBSCRIBER'S NAME:_____ D.O.B._____

ASSIGNMENT OF RELEASE

I authorize Austin Southwest OB/GYN to administer medical treatment as deemed necessary. I understand that the primary insured is financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand the primary insured person will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance compan and assign benefits to otherwise payable to me to Austin Southwest OB/GYN.

_____ _____
Responsible Party Signature Date

Assignment of Benefits Form

Office Policy on Insurance & Appointment Cancellations

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with the business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, and any other health/medical plan to issue payment check(s) directly to Souhail Asfouri, M.D. 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.

Authorization to Release Information

I hereby authorize Souhail Asfouri, M.D. to: 1. Release any information necessary to insurance carriers regarding my illness and treatments; 2. process insurance claim generated in the course of the examination or treatment; 3. allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Souhail Asfouri, M.D. 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 further understand that fees are due and payable on the date that services are rendered and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Appointments/Cancellations

Our policy is to charge a fee of $25.00 for any missed appointments and/or non-cancellation. Please help us serve you by keeping scheduled appointment. We realize your time is valuable and will do our best to see you at the time of your appointment. Please understand that medical emergencies are unexpected delays and are a part of medical care.

_____	_____	_____
Patient or Responsible Signature	Relationship	Date

HIPPA Acknowledgement of Receipt

I, _____ acknowledge that I have received Austin Southwest OB/GYN Notice of Privacy Practices.

Acknowledgement of Review of

Notice of Privacy Practices

Austin Southwest OB/GYN, P.A.

Souhail Asfouri, M.D., PA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physicians in this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other