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Obstetrics & Gynecology
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Please.....Read, Initial, and Sign below

(Initial) _____ **FINANCIAL RESPONSIBILITY:** I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles.

(Initial) _____ **INSURANCE COVERAGE:** I understand that I am responsible for providing Dr. Fanous with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information.

(Initial) _____ **RELEASE OF INFORMATION:** I do hereby authorize Dr. Fanous to release information to Medical Center Hospital or Odessa Regional Medical Center in the event of a scheduled surgery or procedure, emergency care, or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

I do hereby authorize Dr. Fanous to release information to the following individuals:

Name

Relation to Patient

Name

Relation to Patient

(Initial) _____ **HIPPA:** I acknowledge that I have received a copy of Dr. Fanous' Notice of Privacy Practices.

(Initial) _____ **FEE FOR FORMS COMPLETION:** I understand that I will be responsible for paying \$25 for forms completion by Dr. Fanous or staff. (Example: Disability forms, FMLA forms, etc)

(Initial) _____ **FEE FOR "NO SHOW":** I understand that a \$20 "No Show" fee will be accessed for appointments that I do not keep without informing the office to reschedule or cancel.

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Patient Name: _____

Signature: _____

Today's Date: _____