FAMILY & INTERNAL MEDICINE CENTER

Dr. Tahira Qureshi ARNP, MD, FMG, MSN, MBA

Dr. Imtiaz Qureshi MD, FACP

(PLEASE PRINT)

Name: _____ Date of Birth:_____

Social Security#: _____-_____-_____

Male Female Other

Please Circle

Address: _____

City: _____ State:_____ Zip Code:_____

Mailing Address:

_____

Phone #: _____

Email Address: _____

Employer: _____

Insurance Information

Insurance Name:_____

Member ID #: _____ Group #:_____ N/A

Circle N/A if you do not have a group #

Secondary Insurance:_____

Member ID #: _____ Group #:_____ N/A

PHARMACY

Pharmacy Name:_____ Pharmacy Number:_____

Pharmacy
Address:_____

Patient Financial Responsibility

I,_____ understand & agree to the following described below financial office policy.

- **Co-Payments:** Your insurance company requires us to collect copayments at the time of service. Waiving of this co-payment may constitute fraud under federal and state law.
- Credit card Payments are ONLY accepted. We do not accept CASH, there is a 3% processing fee for each credit card usage.
- **Deductible Payment:** If your insurance requires you to meet deductibles before services are covered, payments must be made at the time of service. An $85.00 payment will be due at the beginning of each service. Please note that the $85.00 payment does not constitute payment in full and any additional balance. All balances must be paid upon receiving notification from the practice.
- **Claims Submission:** We will submit you claims and assist you in any way we reasonably can to help get you unpaid claims paid. Payment from your insurance company is expected within 4 to 6 weeks . After 4 to 6 weeks, we will look to you for your payment of the claim in full. **We will be responsible for all non-covered services.** We must have a copy of your most recent insurance cards in order to verify eligibility. Accounts that are 90 days past due are subject to being sent to a collections agency or small claims court for the unpaid bills. **If we receive notification that you are not eligible for coverage or we are not in network with your insurance, you will be responsible for all charges incurred.** Your insurance company may need you to supply additional information directly to them. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if any additional problem is addressed at the time of your appointment; a copay, deductible, or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your current insurance information, you will be responsible for these services.
- **Cash pay Patients:** The amount you pay to schedule appointments may not be your final payment. Other costs that may be accrued for today's appointment are including but not limited to: laboratory test, X-Rays, any injections, special procedures or additional office visit charges.
- **Missed Appointment:** Please note a $45.00 cancellation fee will apply for missed appointments or failure to cancel within 48 hours prior to your scheduled

appointment time. These charges will be your responsibility and will be billed directly to you.

- **Virtual Visits:** Please sign below if you authorize our office to video call you for your virtual appointments and discuss lab works or any other medical emergency.
- **FMLA PAPERWORK HAS A CHARGE OF $50 OR ANY OTHER MEDICAL PAPERWORK FOR LEAVE OF ABSENCES.**

_____ _____

PRINTED NAME *SIGNATURE*

DATE_____

BEHAVIORAL COMPROMISE

Our office and staff are thrilled to have you as our patient, to be of your service, and part of your health care team.
We are committed to give our patients the best possible professional and personalized health care, while focusing on each patient as an individual with different needs.

It is very important to us for you to understand that frustrating situations may occur at times; however this office and the staff does not accept verbal, physical, or profanity abuse either in person, over the phone or social media.

If any unfortunate situation is to occur with either the patient, a family member or companion we will give you one verbal warning, if this unacceptable behavior continues to take place we will unfortunately be obligated to discharge the patient from the practice immediately.

By signing below I hereby certify that I agree, understand and will faithfully follow this office policy.

E-Prescribing is defined as a physician's ability to electronically send an accurate,error free, and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication eros,and enhances the convenience for the patient while maximizing patient safety.

Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribed program such as:

- Formulary and benefit transactions -- gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
- Medication history transactions-- provides the physician with information about medications the patient is already taking to minimize adverse drug events.
- Fill status notification -- allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be filled, has been picked up, not picked up, or partially filled. By signing this consent form, you are agreeing that Dr. Imtiaz and Tahira Qureshi MD can electronically transmit your prescription to the pharmacy directly to your pharmacy of choice.

- Please note that consenting to the E-Prescribing also permits the use of your medication history from other healthcare providers and/or third party benefit players (i.e. your insurance company) for treatment purposes only.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may have changed at any time, if so you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to

revoke this consent in writing, signed by you. However such revocation will not be retroactive.

If at any time you experience financial hardship and need to make special payment plan arrangements, please contact us! We are willing to help as much as we can.

I have read and understand the above statements. I will agree and comply with the financial policies of the office and I am financially responsible for my account.

I hereby provide informed consent to Family & Internal Medicine Center, both Dr. Imtiaz and Tahira Qureshi to enroll me in the E-Prescribed Program.

PLEASE READ BELOW, UNDERSTAND AND SIGN

By signing this form, I understand that:

-Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

-This practice reserves the right to change the privacy policy allowed by law.

-The practice has the right to restrict the use of the information but the practice does not have to agree to these restrictions.

-The patient has the right to revoke this consent in writing at any time and all full disclosures will cease.

-The practice may condition receipt of treatment upon execution of this consent.

May we phone,email, or send a text to confirm your appointment? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, who? _____

Signature: _____