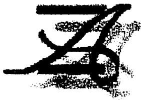

A-Z Internal Medicine

Adel Zahkary MD
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Ph (817) 514-8600 Fax (817) 514-8601

REGISTRATION
(Please Print)

PATIENT INFORMATION

Date:____________________________ Email:____

Name: ____
(Last) (First) (MI)

Mailing Address:____
(Street) (Apt No.) (City) (State) (Zip)

Home Phone: ___________________________ Cell/Work Phone: __________________________ D.O.B.______________

SS#____________________________ DL# ______________________________ Marital Status: __________________

Gender: M or F Occupation: ______________________________________ Employer: ____________________

Emergency contact name: _______________________ Ph#___________________ Relationship to patient: ___________

How did you hear about us: ____

RESPONSIBLE PARTY (If other then patient) Relationship to patient ______________________________

Name: ____
(Last) (First) (MI)

Mailing Address:____
(Street) (Apt No.) (City) (State) (Zip)

Home Phone: ___________________________ Cell/Work Phone: __________________________ D.O.B.______________

SS#____________________________ DL# ______________________________ Marital Status: __________________

Gender: M or F Occupation: __________________________________ Employer: ____________________________

INSURANCE INFORMATION

Primary Ins. Name_________________________________ Secondary Ins Name ______________________________

Ins. Address: ____________________________________ Ins. Address: __________________________________

______________________________________ ____________________________________

Ins. Phone: ______________________________________ Ins. Phone: ____________________________________

Group #: ____ Group #: _______________________________________

ID/Policy #: ______________________________________ ID/Policy #: _____________________________________

Thank you for selecting A-Z Internal Medicine as your health care provider! We appreciate the opportunity to assist you with your health care needs.

All copays and deductibles are due at the time of service. Payment for procedures that are deemed NOT medically necessary is due at the time of service and will NOT be billed to insurance. We accept cash, personal checks, or MasterCard & Visa. There will be a $30 charge for all returned checks. Your services are filed to your insurance within 2 working days of your visit and payment from your insurance is expected within 45 days. If you are not on one of the managed care programs that we are providers for, or this is a third party billing situation, payment is expected at time of service. We will provide you with a billing statement that contains the necessary information for you to file your insurance claims for reimbursement.

If there is a balance due on your account, monthly statements will be sent. If an account falls over 90 days old and there has not been an attempt by the patient or legal guardian to make payment arrangements, or failure to comply the arranged payment schedule, the account may be turned over to a collection agency. You will be responsible for all collection costs (up to 50% of delinquent balance).

It is up to you to know your insurance coverage and keep us notified of any changes in your insurance plane. If services are denied payment from your insurance company as non-covered services, or you have failed to give us your current insurance card, you will be responsible to pay for those changes.

I consent to treatment for the care of the patient indicated on this registration form, I hereby authorize assignment of all medical insurance benefits to A-Z Internal Medicine for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claims. I also authorize release of information necessary to complete referrals to other facilities for additional testing or other doctors for specialized services and care as deemed necessary by my primary physician.

Signature: ____ Date:__________
Patient or legal guardian