



A-Z Internal Medicine

REGISTRATION

Adel Zakhary MD PA

(Please Print)

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Ph (817) 514-8600 Fax (817) 514-8601

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 than 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 #: _____ Copay \$: _____ Group #: _____ Copay \$: _____

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 if patient is a minor)