HIPAA 2016

I, (full name)___________________________________ have insurance with ______________________________(Medical). I authorize Nadia Zaki, MD to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to Athena Health in care of Nadia Zaki, MD. For insurance purposes, I permit a copy of this authorization be used in place of the original. In medicare assigned cases, the physician or supplier agrees to accept the charge determination of the medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charges determination of the medicare carrier**. I must present the correct updated insurance to Dr. Zaki's office at each visit. Failure to do so will delay payment from the insurance company or cause a self balance from a denied claim in which the patient is fully responsible.** If there is a past due balance I will be responsible for full payment before I am seen again by Dr. Zaki. I am responsible for the correct coordination of my benefits. If they are incorrect, the payment for service is my full responsibility. I further understand that if a payment becomes 90 days past due, that my account may be turned over to a collection agency to obtain payments. I also authorize Nadia Zaki, MD to obtain a medication history from an electronic vendor.

________ (initial)

I agree to pay a **NO SHOW FEE of $40.00**, if I do not give a 24hour advance notice to cancel my scheduled appointment.

________(initial)

I understand that there will be a **$35.00 charge for any returned checks.** ________ (initial)

I am aware that **I am responsible for any Co-Insurance and deductibles.** If there are any Co-pays, I understand that **they are due at time of visit. I will obtain all required referrals from my Primary care physician before my appointment with Dr. Zaki. Such as: (**Blue Care Network**,** Health Plus and any others that apply to see Dr. Zaki) **If a required referral is not obtained before my visit, it will be rescheduled until it has been received at our office.**

________(initial)

Yes, I consent that the office may leave a voicemail with personal medical information. ________(initial)

No, I do not consent for the office to leave any personal medical information on my voicemail. ________(initial)

List any persons that you authorize for us to speak to on your behalf regarding your medical information. (spouse, children, friends)

Name ___________________________________relation _________________ phone_______________________

Name ___________________________________relation _________________ phone_______________________

Name ___________________________________relation _________________ phone_______________________

Signature of Patient/Legal Guardian: _______________________________________ Date__________________

Printed name of patient: ____ DOB ____________________

Office staff initial:________ Date____________

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