SHIRAZ MEDICAL GROUP

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KEYVAN SHIRAZI M.D.
DIPLOMAT, AMERICAN BOARD OF INTERNAL MEDICINE

2021 PATIENT INFORMATION SHEET

Date: _____ □ New Patient □ Change of Information Patient no:_____

Referred by_____ How did you hear about us?_____

PERSONAL INFORMATION:

Patient's Name: **First**_____ M.I._____ **Last**_____

Address_____

City_____ **State**_____ **Zip**_____

Sex: □ Male □ Female Employed: □ Yes □ No Employer/School : _____

Phone: Home (_____)_____-_____ Work: (_____)_____-_____

Email: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed Driver License#_____

Name of person to contact in case of emergency: _____

Relationship to patient:_____ **Phone**: (_____)_____-_____

Preferred Language: _____ **Interpreter needed:** □ yes □ no

HEALTH PLAN INFORMATION: Pharmacy Name and location_____

No. of Health Plans: □ One □ Two □ Three
Name of Health Plan_____

Insurance ID #_____ Group No. _____
Relationship to Insured: □ Self □ Wife □ Husband □ Child □ Parent □ Other_____

I hereby consent that Shiraz Medical Group, Inc. provide me with all the health care services that, at his discretion, is necessary for my treatment.
I hereby authorize Shiraz Medical Group, Inc. the release of any medical or other information necessary to the health plans, government agencies, attorneys, or their representatives for processing the claims.
I hereby authorize the health plans, government agencies, and attorneys to pay Shiraz Medical Group, Inc. the medical & surgical benefits allowable as payment towards the total charges for medical treatment, which is not covered by this assignment, and pay them promptly.
I understand that if for any reason my account is overdue more than 60 days, I pay interest at the rate of 12% per annual (1% per month) on all account balances. Further, I understand that if my account is assigned to any collection agency, there is a (25%) collection charge above and over the medical charges.
I am aware that upon using my health plan benefits for any services rendered by any out of network provider, I will be going out of network and exercising my "OPTOUT BENEFITS" choice.
I acknowledge that I have read this form and understand it's contents.

Patient's Signature_____ **Today's Date**_____

SIGNATURE ON FILE

5 YEAR CONSENT FORM: MUST BE UPDATED IF NOT SEEN IN 2 YEARS

MY NAME IS_____
(PLEASE PRINT FULL NAME)

MEDICAL INFORMATION CAN BE DISCUSSED WITH:
PATIENT ONLY:_____ FAMILY MEMBER OR FRIEND:_____
(PLEASE PRINT FULL NAME)

RELATIONSHIP_____ PHONE NUMBER:_____

DETAILED MESSAGES REGARDING TEST RESULTS CAN BE LEFT ON THE ANSWERING MACHINE

YES_____ NO_____ PHONE NUMBER_____

FINANCIAL INFORMATION CAN BE RELEASED TO:
PATIENT ONLY:_____ FAMILY MEMBER OR FRIEND:_____
(PLEASE PRINT FULL NAME)

Do you have an Advance Directive : □ Yes □ No

Would you like information regarding the Advance Directive : □ Yes □ No

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

PLEASE CHECK EVERY SPACE

_____ **I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES**

_____ **I AUTHORIZE USE OF THIS SIGNATURE/FORM ON ALL MY INSURANCE SUBMISSIONS**

_____ **I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL**

_____ **I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT HELPING ME OBTAIN PAYMENT**

_____ **I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR**

_____ **I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL**

_____ **I UNDERSTAND THAT CODES WILL NOT BE CHANGED AFTER CLAIM IS SUBMITTED**

_____ **I UNDERSTAND THAT I AM RESPONSIBLE FOR UNDERSTANDING MY INSURANCE COVERAGE**

_____ **I UNDERSTAND MY INSURANCE MAY NOT PAY FOR ROUTINE TESTS, BLOODWORK OR X-RAYS**

_____ **I AUTHORIZE MY MEDICAL RECORDS BE MAILED/FAXED TO MY OTHER PHYSICIANS**

_____ **I UNDERSTAND THAT THERE WILL BE $30.00 CHARGE IF I AM A NO-SHOW FOR AN APPOINTMENT**

Patient's Signature_____ **Today's Date**_____

**REQUIRED BY HEALTH INSURANCE PROTABILITY AND ACCOUNTABILITY ACT

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability ACT of 1996 (HIPAA), I have certain rights to privacy regarding my protected my protected health information. I understand can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your *NOTICE OF PRIVACY PRACTICES* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *NOTICE OF PRIVACY PRACTICES* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *NOTICE OF PRIVACY PRACTICES.*

I understand that I may request in writing that you restrict how much private information is used or disclosed to carry out treatment, payment of health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempt to obtain the patient's signature in acknowledgment on this Notice Of Physician Practices Acknowledgment, but was unable to do as documented below.

Date:	Initials:	Reason:

This form was checked by: _____ Date: _____