PATIENT REGISTRATION

First Name: _____ MI: ____ Last Name: _____

Email Address: _____ Date of Birth: _____/_____/_____ Sex: M F

Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: S D M W Student: No Full Time Part Time

Employer: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Cross Streets: _____ & _____

Mail Delivery Pharmacy: _____ Contact Number:(_____) _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone:(_____) _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relationship: _____
Claims Address: _____ City: _____State: _____ Zip: _____

Secondary Insurance: _____ Phone:(_____) _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relationship: _____
Claims Address: _____City: _____ State: _____ Zip: _____

I hereby give permission to Dr. Zaki Lababidi, MD FACC FSCAI and Dr. Khaled Albasha MD FACC, to treat me as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered; and if necessary, I agree to pay all reasonable and customary collection fees and /or attorney's fees that may be incurred due to any delinquent accounts I may have. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

Release of Private Health Care Information

I hereby give permission for the following person(s) to contact the office on my behalf to discuss my private healthcare information with the providers/staff or billing personnel of Gilbert Cardiology:

Name: _____ Relation: _____ Phone:(_____) _____
Name: _____ Relation: _____ Phone:(_____) _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____ Phone:(_____) _____
Name: _____ Relation: _____ Phone:(_____) _____

- Patient Signature: _____ Date: _____/_____/_____

Insurance Information/Policy/Responsibility

As a patient, you are responsible for knowing your insurance policy and verifying participation. For example, you will be responsible for any charges if any of the following apply:

- Your health plan requires prior authorizations or referral by a primary care physician (PCP) before receiving services at **Gilbert Cardiology**, and you have not obtained such an authorization or referral.
- You receive services in excess of such authorization or referral.
- Your health plan determines that the services you received at **Gilbert Cardiology** are not medically necessary and /or not covered by your insurance plan.
- Your health plan coverage has lapsed or expired at the time you receive services at **Gilbert Cardiology**.
- You have chosen not to use your health plan coverage. If you are not familiar with your insurance plan coverage, we recommend you contact your carrier or plan facility.

Gilbert Cardiology will attempt to obtain referrals from the patients primary care physician (PCP) if one is required, however it is patient responsibility to make sure that referral is obtained. **Gilbert Cardiology** will also try to obtain prior authorizations for any testing that is performed in the office through the patient's insurance company. **Gilbert Cardiology** will inform the patient if the testing is *DENIED* by insurance *PRIOR* to the patient's scheduled appointment. However, it is up to the patient to determine any out of pocket cost and/or expenses for the particular testing.

Patient Name (print):_____

Patient Name (signature):_____

Date:_____

Financial Policy and Patient Responsibility

Patient Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-pays. If you are not familiar with your plan coverage. We recommend you contact your carrier directly.
- To obtain a referral from their primary care physician and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay at the time of arrival.
- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month (or 18% per year) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- To facilitate payment of claims by contacting their insurance carrier when claims have not been paid.
- A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgements:

I have read and understood the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard or Visa. I agree that if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

➢ _____

Printed Patient Name Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claim forms for me by Dr. Zaki Lababidi, MD FACC FSCAI, and Dr. Khaled Albasha MD FACC. I also authorize my insurance carriers to make payments directly to these companies.

➢ _____ _____

Signature Date

Gilbert Cardiology

Authorization for Medical Records Request/ Release

- Patient Name: _____
- Date of Birth:_____/_____/ _____

You are hereby authorized to release/request any medical notes, reports, labs, operative reports and films to/from Dr. Zaki Lababidi, MD FACC FSCAI, and Dr. Khaled Albasha MD FACC.

(FOR OFFICE TO FILL OUT)

We specifically request:

_____

_____

_____

I hereby release Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, and its staff from liability and all claims of nature whatsoever, pertaining to disclosure of this information.

If I have requested these records for my own personal use, I am responsible for the safe keeping of these records. Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, and its staff is not responsible if these records were to get damaged or lost once given to me.

- _____

  Patient Signature/Personal Representative Signature

(FOR OFFICE TO FILL OUT)

Dr. Name: _____

Phone Number: _____

Fax Number: _____

Appointment Cancellation Policy

If you do not cancel your appointment that is scheduled with Dr. Zaki Lababidi, Dr. Khaled Albasha, Shari McClurg, MSN, NPC, or Lindsey Estes, PA-C, **24 hours** prior to your appointment time, you will incur a $**100** charge.

If you do need to cancel an appointment, the staff at Gilbert Cardiology will be more than happy to accommodate you.

I have read and understood the policy at Gilbert Cardiology regarding cancelled appointments.

- Print Name: _____
- Signature: _____
- Date: _____/_____ /_____

Acknowledgement of Privacy Practices

Notice of Acknowledgement of Privacy Practices:

I acknowledge that I have received, been offered, or reviewed Gilbert Cardiology's Notice of Privacy Practices.

- Patient Signature: _____ Date: _____

OR

- Personal Representative Signature: _____ Relation: _____
  Date: _____

If you would like any person(s) to be able to communicate with Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, or office staff about your care, please include their name below. You may add or remove any person at any time.

You may discuss my care with the following person(s):

_____ _____

Name **Name**

_____ _____

Name **Name**

Advanced Beneficiary Notice (ABN)

If you have Medicare, please complete the form.

If you do not have Medicare, please provide your name, signature, and today's date.

- Patient's Name: _____
- Medicare Number: _____-_____-_____
- Authorization Period: From: _____/_____/_____ To: _____/_____/_____
  (***Or until rescinded)

"I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I also authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim of any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

- Patient's Signature:_____
- Date: _____/_____/_____

Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003

Your Health Information Rights:

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy:
You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit your request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information complied in reasonable anticipation of, or for us in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conduction the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Gilbert Cardiology in writing. The practice reserves the right to charge for copying of records per the state regulations.

Amend:
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial,

An accounting of Disclosures:
You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Gilbert Cardiology will provide the first accounting to you in any 12-month period without charge, upon your written request. The cost for subsequent requests for an accounting within the 12-month period will be $10.00

Request Restrictions:
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about a procedure that you had. We ask that you submit these requests in writing. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communication:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice:
You have the right to a paper copy of this notice. You ay ask us to give you a copy of this notice at any time. Even if you have agree to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us by calling (480) 786-9100 and asking for the Privacy Officer or by contacting the secretary of the Federal Department of Health and Human Services by calling 1-800-368-1019, or by contracting the Office of Civil Rights regional office. All complaints must be also submitted in writing within 180 days of when you knew that the act or omission complained of occurred. You will not be penalized for filing a complaint.

Other Uses or Medical Information:
Other uses and disclosures of medical information not covered by this Notice of the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke that permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosure we have already made with your permission and we are required to retain our of the care that we provided to you.

Privacy Officer: Chief Financial Officer.
Telephone Number: (480) 786-9100.

This information is advisory only. Final interpretation is the responsibility of the regulatory or accrediting body administering the standard or regulation referenced.

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Gilbert, AZ 85297

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Fax: (480) 786-0742