Patient Intake Form PCAG

Demographics:

Patient's Name: _____ DOB: _____

Gender: Male: ❑ Female: ❑ Parent/Guardian's Name: _____

Relationship to patient: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact name and phone: _____

Doctor:

Primary Care Doctor: _____Phone_____Fax_____

Referring Doctor: _____Phone_____Fax_____

Pharmacy:

Pharmacy Name: _____

Address: _____

Phone: _____Fax_____

Insurance:

Insurance Company: _____ Type: ❑PPO ❑HMO

ID: _____ Group #: _____

Subscriber Name: _____ Relationship to patient_____

Address if different:_____DOB: _____

Referral: YES: ❑ NO: ❑ _____

Secondary Insurance: YES: ❑ NO: ❑ _____

If yes, ID: _____ Group #: _____

Parent/Guardian Information:

Name: _____ Date of Birth: _____

Gender: M F Marital Status: S M W D

Address, City, State, Zip: _____

Phone #: _____ Driver's License # _____

Signature of Parent/Guardian_____ Date _____

Revised 6/9/2020

Progressive Child & Adolescent Gastroenterology

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.
- Audio and or video recording of conversations during office visits is subject to federal and privacy laws that prohibit this unless consent is obtained.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Name(s):

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Progressive Child & Adolescent Gastroenterology
S. Madani M.D P.C, 888 W Big Beaver Suite 404 Troy MI 48084, Fax: 248-717-2411, Phone: 248-717-2410

AGREEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____DOB: _____

Thank you for choosing us as your/child's health care provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of parent/patient financial policies of S.Madani M.D. P.C, DBA, Progressive Child & Adolescent Gastroenterology

Parent/Patient Financial Responsibilities:

- The parent (or patient's guardian, if a minor)/patient is responsible for the payment of copays, deductibles and coinsurance at time of visit.
- Parents/patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- It is the parent/patients' responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- Should the patient's insurance carrier refuse payment (e.g., non-covered services, failure to secure a referral from primary care physician, the doctor is not a panel member of my medical group etc.), the parent/patient will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.
- It is the parent/patient's responsibility to provide current and accurate insurance information, including any changes in coverage at initial and every subsequent visit.
- In the event the parent/patient fails to pay for services rendered when due, he/she agrees to pay all costs associated with collection (including but not limited to collection agency fees) as part of the collection process, and understands that will affect their credit score.
- We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. The parent/patient is required to pay $25 for a no show appointment. We urge the parent/patient to call 24 hours prior to cancelling an appointment. I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.
- Asking this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and will result in a fraudulent act.

By my signature, I certify to having read the above statements and fully understanding my financial responsibility for all care rendered for my child/me, at this practice regardless of any changes in my insurance coverage.

Parents Name/ Signature (or responsible party If minor)
Date: _____