Patient Registration

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ☐ Male ☐ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ Cell phone number: _____ Work number: _____

Email: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name _____ Employer phone number: _____

Employer complete address _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ☐ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____ Sex: ☐ Male ☐ Female

Home phone number: _____ Cell phone number _____ Work number: _____

Complete mailing address – if different from patient _____
(Street, city, state, zip code, county)

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____

Home phone number: _____ Cell phone number: _____ Work number: _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ☐ Self-pay (no insurance)

Primary insurance: _____ Patient relation to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary insurance: _____ Patient relation to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Prescription/Rx provider: _____ (if different from insurance carrier)

Full name of subscriber: _____ (complete below if different from patient, spouse or guarantor)

Subscriber date of birth: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ Employer size: ☐ 0 – 19 employees ☐ 20 – 99 ☐ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	Do you want anyone to know you are here? ☐ Yes or ☐ No

General Consent for Care and Treatment Consent

TO THE PATIENT: ***You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date:**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	**Employee Job Title**
Signature of Witness	**Date**

Zam Zam Family Clinic

HIPAA ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The following information on this form is used to facilitate our communication process with you as we strive to provide you with specifies your rights about this authorization under the Health Insurance Portability and Accountability amended from time to time ('HIPAA')

Notice of Privacy Practices : You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Patient information (Please print clearly):

_____ _____ _____

(First Name) (Last Name) (Date of Birth)

_____ _____

Email (important for patient portal) Phone Number

If we can't reach you at the telephone number listed above, Zam Zam Family Clinic may contact you, including leaving messages.

I authorize Zam Zam Family Clinic to disclose protected Health Information to the following persons:

1. _____ _____ _____

(Name) (Relationship) (Phone Number)

2. _____ _____ _____

(Name) (Relationship) (Phone Number)

Information to be disclosed (CIRCLE ALL THAT APPLY)

1.All medical info. 2. Lab results. 3. All billing and account information.

I hereby authorize and instruct Zam Zam Family Clinic and affiliates, employees and agents of (collectively "ZZFC") to release my entire patient record including information related to diagnosis, treatment, claims payment and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number. I understand that any personal health information or other information released to the person or organization identified above my be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that Protected Health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and in person. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand Zam Zam Family Clinic cannot require me to sign this authorization. If you refuse to sign this authorization and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

_____ _____

(Patient signature) (Date)

Zam Zam Family Clinic

Office Policies

Phone Calls

Every phone call is important to us and we will attempt to answer/return calls in a timely manner. However, being that we are seeing patients throughout the day we ask that you give us 24-48 hours to return nurse calls. Medication refill requests require 48 hrs notice for nurses to respond to your request and determine if you will need to come in for medication or we can send. If you call with an urgent matter we will make every effort to respond immediately.

Appointments

- When scheduling appointments please advise the receptionist of the reason you are being seen.
- Please arrive 10 to 15 minutes before your scheduled appointment so we can review, update, or complete your demographic information. Also please notify us of any changes in your name, address, phone number or insurance.
- Copays, deductibles and private pay payments are due at time of service.
- Please bring your medications bottle or a complete list of your medications with you to each appointment.
- Please be on time for your appointments. If you arrive late you may be asked to reschedule your appointment or give the option to wait until scheduled patients have been seen.
- If you need to cancel or reschedule your appointment we ask that you give a **24 hour notice** to avoid a no show fee.

I understand if I have 3 or more no show appointments within a year I may be dismissed from the clinic.

Payment Responsibility

I understand that services rendered at time of visit will be billed to my insurance. However, any claims that are partially paid or denied by my insurance carrier will thereafter become my responsibility. This applies to all insurances.
I understand it is my responsibility to pay any co-pays, deductibles, co-insurance, non-covered services or any other balance not paid for by my insurance or third party payor within a reasonable time period, not to exceed 60 days.

We at Zam Zam Family Clinic understand that some balances may not be paid in full at time of service and we will be happy to assist you in making payment arrangements.

Fees

If an appointment is not canceled 24 hours prior to appointment time or you do not show for an appointment you will be charged a $25 fee.
If you need to obtain medical records outside of myChart you will be charged a $20 fee for copying and mailing costs. We may charge the following $.75 per page for the first 20 pages. $.65 per page 21-100 & $.50 if copies exceed 100 pages.
An upfront fee of $30 will be collected for administrative tasks such as completing disability forms, FMLA, biometric screening form, sports physical and some medical records request. These tasks may require up to 10 days to complete.
Our office requires additional co-pays for procedures such as Imaging, Ultrasounds, Exams, or any procedures that can be performed in the hospital but the patient prefers to get services in the office. It is a convenience fee for having procedures done in the office.

Uncooperative Patients/ Terminating Services

Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and/or presents difficulties to physicians and staff. Failure to pay a debt/account. We ask that you refrain from the use of foul language or any other aggressive behavior while in the office or over the phone. Any disruptive or harassing staff in person or over the phone will be deemed inappropriate and will result in immediate dismissal from the office.

By signing this document I am acknowledging receipt of office policies and financial responsibility. This will remain in effect until revoked in writing

Date: _____ Signed: _____

Zam Zam Family Clinic
FINANCIAL POLICY

It is our policy to verify your identity with a photo ID and current insurance card. It is your responsibility to provide us with a current address, telephone number, email address (if available) and a preferred method of contact. It is also your responsibility to update these at each visit.

We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan. It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions. Any charges which are accrued will be the responsibility of the patient.

Patients who have a HMO policy must ensure their physician is listed on their insurance card. If not, the insurance provider will not cover the services provided. Any unpaid charges will be the patient's responsibility.

If you receive a bill from an outside facility such as LabCorp, Quest you will need to contact them directly.

Copays and deductibles are due at the time of each visit. Please do not ask us to bill your portion of today's visit. Mailing statements is time consuming and costly to our practice. We are in network with Medicare, Medicaid and most commercial insurance plans. As a courtesy to our patients, we will file in-network insurance claims. If your visit is not paid within 45 days from the date of service or denied by your insurance carrier, it is your responsibility to follow up and notify us of the status of your claim. **After 90 days from the date of service, the balance will be your responsibility and payment will be due.**

We make every effort to determine what your portion of each visit will be. Payments collected at each visit are an **ESTIMATE** based on the information we have gathered from your insurance company. Your actual benefit is determined when the claim is processed.

You, the patient are responsible for the bill if:

- **Your insurance provider denies the charge as a non-covered service**
- **Your insurance coverage is not active at the time of service**
- **Your insurance provider does not answer the claim in 90 days**
- **Your insurance provider denies the claim for lack of referral**
- **Your insurance denies the claim as out of network**
- **Workers compensation denies the claim due to negligence on your part**

It is your responsibility to be aware of your insurance benefits, required pcp referrals, in / out of network benefits. If you have any doubts, you should contact your insurance company for clarification of these issues.

I have read the above policy and understand and agree to these terms.

_____ _____

(Patient signature) **(Date)**

Zam Zam Family Clinic
965 Oakland Rd. Bldg 3 Suite D.
Lawrenceville, GA 30044
PH:770-807-0061 FAX:770-733-1131

Authorization for Release of Medical Records

Patient Name:_____ DOB:_____

Patient Phone Number:_____

I hereby authorize the release of my protected health information to Zam Zam Family Clinic to (Release / Request) the following information: To provide copies of my medical records. The information may include other detailed information such as other mental health notes.

- ❑ Complete Medical Records
- ❑ Labs
- ❑ Diagnostic Testing / Imaging
- ❑ Other: _____

Authorization to receive the disclosure you are authorizing Zam Zam Family Clinic to obtain Medicare Records from below:

_____
Name of Healthcare Provider/ Facility

_____
Street Address

_____
City, State, Zip code

_____ _____
Phone Number FAX Number

_____ _____
(Patient Signature) **(Date)**