Noushin A. Firouzbakht, M.D., P.A.

•PATIENT INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) _____

Date of Birth: _____/_____/_____ **(MM/DD/YYYY)** **SOCIAL SECURITY NUMBER (optional):** _____-_____-_____

ADDRESS: _____ **EMAIL:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME NUMBER: (_____) _____- _____ **MOBILE NUMBER:** (_____) _____- _____ **WORK:** (_____) _____- _____

CONTACT METHOD PREFERED: ☐ **HOME PHONE** ☐ **MOBILE NUMBER** ☐ **WORK** ☐ **EMAIL**

MARITAL STATUS: (PLEASE CHECK RELEVANT STATUS) ☐ **SINGLE** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **MARRIED**

RACE/ETHNICITY (optional): _____

EMPLOYER_____ **EMPLOYER'S ADDRESS** _____

- **PREFFERED PHARMACY:** _____ **PHARMACY PHONE NUMBER:** (_____) _____- _____

•COMPLETE ONLY IF PATIENT IS A MINOR

PARENT(S) / LEGAL GUARDIAN NAME: _____ **PHONE:** (_____) _____- _____

ADDRESS: _____ **ALT PHONE:** (_____) _____- _____

•EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____

HOME NUMBER: (_____) _____- _____ **CELL:** (_____) _____- _____ **WORK:** (_____) _____- _____

•INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **POLICY/ID NUMBER** _____

NAME OF POLICY HOLDER: _____ **GROUP/ACCOUNT NUMBER** _____

DOB _____/_____/_____ **EMPLOYER NAME:** _____

EMPLOYER ADDRESS: _____ **WORK NUMBER:** (_____) _____- _____

SECONDARY INSURANCE: _____ **POLICY/ID NUMBER** _____

NAME OF POLICY HOLDER: _____ **GROUP/ACCOUNT NUMBER** _____

DOB _____/_____/_____ **EMPLOYER NAME:** _____

EMPLOYER ADDRESS: _____ **WORK NUMBER:** (_____) _____- _____

• *PAYING INSURANCE BENEFITS*

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO NOUSHIN A FIROUZBAKHT, MD, PA. THIS ASSIGNMENT IS FOR SERVICES RENDERED TO ME BY NOUSHIN A FIROUZBAKHT, MD, PA THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY MYSELF IN WRITING. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THIS PAYMENT. I UNDERSTAND THAT FAILURE TO NOTIFY NOUSHIN A FIROUZBAKHT, MD, PA OF ANY CHANGES OR INSURANCE COVERAGE WILL RESULT IN THE FINANCIAL OBLIGATION TO REST FULLY ON MYSELF REGARDLESS OF ANY CONTRACT BETWEEN THE INSURANCE COMPANY AND NOUSHIN A FIROUZBAKHT, MD, PA.

_____ _____/_____/_____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

• *HIPAA DISCLOSURE*

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT NOUSHIN A FIROUZBAKHT MD PA, OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY NOUSHIN A FIROUZBAKHT MD PA TO: A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY THROUGH NOUSHIN A FIROUZBAKHT MD PA OR NETWORKING ORGANIZATIONS, AND D) CONSENT TO PROPERTY TRANSFER OF SPECIMEN (TISSUE OBTAINED DURING MEDICAL TESTING) TO NOUSHIN A FIROUZBAKHT MD PA.

I HAVE BEEN INFORMED BY YOU OF 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 OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MY OFFICE OR BY CONTACTING THEM AT 3501 N. MACARTHUR BLVD., SUITE 600, IRIVING, TX 75062. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____ _____/_____/_____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

•*RELEASE OF INFORMATION*

_____ NOUSHIN A FIROUZBAKHT MD PA MAY NOT DISCUSS MY HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.

_____ NOUSHIN A FIROUZBAKHT MD PA MAY DISCUSS MY HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

•*CANCELLATION&NOSHOWPOLICY*

Any appointment you are unable to keep must be cancelled at least 24 hours in advance of the appointment time. **You may be charged $25 for appointments not cancelled at least 24 hours in advance**. The same policy applies if you do not show to your appointment. Insurance companies do not cover this expense. This charge will be the sole responsibility of the patient. You may be dismissed from the practice if you repeatedly NO SHOW for scheduled appointment without providing sufficient notice.

_____
Initials

•*MEDICATIONREFILLPOLICY*

Please contact your pharmacy for medication refills first. Your pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. The physician on call does not refill medications after hours or on the weekend. Please allow sufficient time for us to process your refill request.

_____
Initials

•*DISCLOSURE OF GROUP PRACTICE INTEREST IN HOSPITALS AND ANCILLARY SERVICES*

YOUR PHYSICIAN AT NOUSHIN A FIROUZBAKHT MD PA HAS EXERCISED HIS/HER INDEPENDENT PROFESSIONAL JUDGEMENT, IN DETERMINING IF IT IS IN YOUR INTEREST TO RECEIVE CERTAIN PRESCRIBED MEDICAL CARE (FROM FEMALE AS WELL AS MALE PHYSICIANS) AT TEXAS HEALTH RESOURCES AT FORT WORTH OR BAYLOR MEDICAL CENTER AT FORT WORTH (THE "HOSPITALS") AND/OR ONE OF SEVERAL ANCILLARY SERVICES. "ANCILLARY SERVICES" INCLUDES SEVERAL MEDICAL SERVICES INCLUDING LABORATORY SERVICES, DEXA SCANS, CT SCANNER, ULTRASOUND AND OTHER IMAGING EQUIPMENT. THE PURPOSE OF THIS DISCLOSURE STATEMENT IS TO INFORM YOU THAT, NOUSHIN A FIROUZBAKHT MD PA, THE MEDICAL GROUP PRACTICE OF WHICH YOUR PHYSICIAN IS A PARTNER OR EMPLOYEE, POSSESSES NO OWNERSHIP INTEREST IN THE HOSPITALS AND ANCILLARY SERVICES, HOWEVER WITH REGARDS TO THE HOSPITALS, THEY DO HAVE PRIVILEGES TO UTILIZE THESE FACILITIES FOR YOUR CARE. DECISIONS REGARDING THE ADMISSION, RECOMMENDATION, REFERRAL OR ANY OTHER FORM OF ARRANGEMENT FOR UTILIZATION BY PATIENTS OF YOUR PHYSICIAN OF SPECIFIC SERVICES OR FACILITIES ARE MADE WITH REGARD TO THE BEST INTERESTS OF EACH INDIVIDUAL PATIENT, BUT DO NOT INCLUDE CONSIDERATION WITH REGARDS TO THE GENDER OF SUCH RECOMMENDATION, ADMISSION, OR REFERRAL.

_____ _____/_____/_____

(SIGNATURE OF INSURED/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

•*FINANCIAL POLICY PATIENT CONSENT FORM*

NOUSHIN A FIROUZBAKHT MD PA RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDER REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

I. **PAYMENT: PAYMENT IS EXPECTED AT THE TIME OF SERVICE. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, NOUSHIN A FIROUZBAKHT MD PA will begin various collection activities including, but not limited by submitting the past due account to a collection agency.**

II. **SELF PAYMENT (PRIVATE, CASH PAYMENT): If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional services.**

III. **MANAGED CARE: ALL MANAGED CARE (HM, PPM, etc.) CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.**

IV. **MEDICARE: NOUSHIN A FIROUZBAKHT MD PA is a participating provider with the Medicare Program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.**

V. **CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of NOUSHIN A FIROUZBAKHT MD PA.**

VI. **MINORS: If the patient is a minor, he/she must be accompanied by a Parent/Guardian/Appointed Agent for each office visit. If the patient is to be seen without the Parent/Legal Guardian, prior consent must be given in writing and signed by the Parent/Legal Guardian. Any appointed agent listed below may bring the minor to any appointment scheduled. We will maintain a copy of this consent within the minor's electronic health record.**

Appointed Agents (optional):

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

VII. **CLINICAL RESEARCH: NOUSHIN FIROUZBAKHT, MD, PA participates in clinical research studies, and NOUSHIN FIROUZBAKHT, MD, PA Physicians are compensated (receive money) by the study sponsors to perform research trials. You hereby authorize NOUSHIN FIROUZBAKHT, MD, PA to access your medical information for the purpose of evaluating your eligibility to partake in such clinical research studies. You also agree to be contacted by NOUSHIN FIROUZBAKHT, MD, PA regarding the possibility of being enrolled in such a research study. You are UNDER NO OBLIGATION to enroll in any study. Study participation is voluntary and refusal to participate will in no way involve penalty or loss of benefits to which you are otherwise entitled. Refusal to participate in a research study will not affect your continuing care with a NOUSHIN FIROUZBAKHT, MD, PA Physician. Participation in a research study will not interrupt your regular care with a NOUSHIN FIROUZBAKHT, MD, PA.**

VIII. **SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. You agree to provide such information as outlined below. You agree to notify provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.**

Initial/Complete as applicable:

_____ I DO NOT have Secondary Insurance Coverage

_____ I DO have Secondary Insurance

NOUSHIN FIROUZBAKHT, MD, PA firmly believes that a good patient/phyisican relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 878-2667.

_____ _____/_____/_____

(SIGNATURE OF INSURED/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**