

WELCOME TO OUR PRACTICE!

Hamid Zadeh, M.D.

2435 Marshall Road
Imperial, CA 92251



PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Email Address _____
Last Name First Name Initial
Address _____ Home Phone _____
City _____ State _____ Zip _____
Sex: M F Minor Single Married Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Whom may we thank for referring you? _____
In case of emergency, whom should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. **Hamid T. Zadeh** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of the services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Primary Doctor _____

Pharmacy _____



HAMID T. ZADEH, M.D.

2435 Marshall Road Imperial, CA 92251 P: (760) 550-6327 F: (760) 550-6331

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PERMISSION TO LEAVE TELEPHONE MESSAGES

I hereby acknowledge that I received, read and understand the Notice of Privacy Practices that are implements by Hamid T. Zadeh, M. D., I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

I understand that Dr. Hamid T. Zadeh and employees will make reasonable efforts to protect my privacy and keep my patient information confidential and secure.

SIGNED: _____ **DATE:** _____

PRINT NAME: _____ **PHONE:** _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

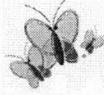
I hereby give my permission to leave telephone message that may contain some personal health information as follows:

Permission to leave messages.

or

Do not leave any messages.

SIGNATURE: _____ **DATE:** _____



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DESIGNATION OF PERSONAL REPRESENTATIVE

Name: _____ Date: _____

DOB: _____

As required by the Health Information Portability and Accountability Act of 1996, you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information.

Name: _____

Address: _____

Phone: _____ Cell: _____

What relationship is this person to you? _____

This person is to be afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

*Hamid T. Zadeh, M. D.
2435 Marshall Road
Imperial, CA 92251*

I further understand that any such revocation does not apply if that person or persons authorized to use or disclose my protected health information have already taken action on my behalf.

SIGNATURE: _____ **DATE:** _____

REVOCAION SECTION:

I hereby revoke this designation of a personal representative.

SIGNATURE: _____ **DATE:** _____



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Missed/Cancelled Appointment Policy

Due to the high number of patients requiring care, waiting times for appointments can be long. Missed or cancelled appointments will waste resources and prevent other patients from receiving care in a timely manner.

Hamid Zadeh, M.D. will charge a missed/cancelled appointment fee for each appointment that is missed or cancelled without adequate notice. A missed/cancelled appointment is an appointment that is:

- Missed without notice
- Cancelled with less than 24 hour notice
- Missed due to arriving 15 minutes or beyond that scheduled appointment time

If you must cancel a scheduled appointment, please notify our office by phone at least 24 hours before the appointment. Messages are acceptable and can be left at all times including evenings and weekends.

The fees for missed/cancelled appointments are as follows:

- **Office Visits/Follow-ups** **\$25.00**
- **Procedures/Ultrasounds** **\$75.00**

These fees must be paid in full prior to being seen at your next visit. You are responsible for any missed/cancelled appointment fees you are charged; your insurance company will not be billed.

If you miss 3 appointments without any notice, we will be unable to continue your care. This means discharge proceedings from our office can begin. _____ **PLEASE INITIAL.**

It is required that you sign and date this form. This acknowledges that you have read and understand our policy.

Signature _____ Date _____

Name of legal guardian if signing for the patient _____



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Notice of Privacy Policy and Practices

Introduction

In accordance with Health Insurance Portability and Accountability Act of 1996 (known as HIPPA), our practice is required to protect the privacy of your personal health information. This document will provide notice of our privacy policy and practices including your rights and our legal duties concerning your health information and records. Please review this document; you will be asked to sign a form acknowledging your opportunity to review this notice. A copy will be provided upon request.

Summary

Since you are a patient who has consented to receive care from the physician and staff of Dr. Zadeh, the law allows us to use and disclose your medical information for specific purposes. These include uses and disclosures for purposes of treatment, obtaining payment of services, and health care operations which will be explained below, in addition, the law may authorize disclosures for reasons of public health and interest including disaster relief, law enforcement and formal judicial and administrative proceedings. With your permission, your medical information may be disclosed to family members and/or others of your choosing who have an involvement of interest in your health status. Any other disclosure will require your written authorization.

You have the following rights that will be respected by this policy:

1. To examine or receive a copy of your medical record of care that has been provided by Hamid T. Zadeh, M.D. (copying may involve a nominal cost).
2. To receive an accounting of the disclosure of your medical information that do not involve treatment, payment or health care operations.
3. To request a correction or amendment of your medical record.
4. To specify other restrictions on the use and disclosure of medical information.
5. To request a specific method or avenue in receiving a communication involving confidential information.
6. To file a formal complaint if you feel that an improper use or disclosure occurred.

The entire notice will go into more detail regarding the specific issues involved in this policy. Please review it.

Receipt of Notice of Privacy Policy and Practices

I acknowledge that I have received or have been given the opportunity to review a copy of:

Notice of Privacy Policy and Practices

I understand that an amendment to this policy may occur in the future and that a current summary of this or the amended notice will be posted in the medical office for my review. A copy of the amended notice will be made available upon my request.

Print Name

Date

Signature

Relationship to patient (if other than patient)



Hamid Zadeh, MD., INC

2435 Marshall Ave
Imperial, CA 92251

**Patient Financial Responsibility
Primary Insurance and secondary Insurance**

_____ I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, in office screening testing, NST, Ultrasounds and any other screening ordered by the doctor or staff.

_____ I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

_____ I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

_____ I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

_____ I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

_____ I agree, If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

_____ If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our office does not make the rules. They are determined by your specific medical insurance.

Printed Patient Name (and Guardian Name if applicable) Patient or Guardian Signature Date

Name Relationship

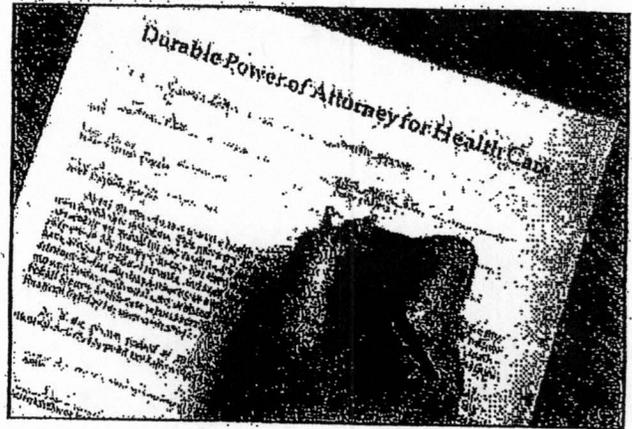


Advance Medical Directive

An advance medical directive is a form that lets you plan ahead for the care you'd want if you could no longer express your wishes. This statement outlines the medical treatment you'd want or names the person you'd wish to make health care decisions for you.

Writing Down Your Wishes

- Decide what is important to you and the treatment you'd want.
- An advance directive is important whether you're young or old. Injury or illness can strike at any age.
- Some states allow only one kind of advance directive. Some let you do both a Durable Power of Attorney for Health Care and a Living Will. Some states put both kinds on the same form.



A Durable Power of Attorney for Health Care

- This form lets you name someone else to be your agent.
- This person can decide on treatment for you *only* when you can't speak for yourself.
- You do *not* need to be at the end of your life. He or she could speak for you if you were in a coma but were likely to recover.

A Living Will

- This form lets you list the care you want at the end of your life.
- A living will applies *only* if you won't live without medical treatment. It would apply if you had advanced cancer or a massive stroke.
- It takes effect *only* when you can no longer express your wishes yourself.

Advanced Directive Education: Date _____
 Refused: _____ Yes: _____ Initials: _____