Robert Samaan, MD, INC.

Patient Information

Name: First_____ **MI**_____ **Last**_____

Address_____**City**_____ **State**_____ **Zip**____

Home# _____ **Cell#** _____**Work#** _____
Preferred Phone #:_____

DOB:__/___/_____ **Sex: M / F** **Marital status:**_____
SSN# _____ **Race/Ethnicity:**_____
Emergency Contact:_____ **PH#**_____

Email:_____
Employer: Name_____ **PH#** _____
Employer Address:_____

Insurance: Name:_____ **ID#**_____
Group#_____ **Policy Holder: Name:**_____
Policy Holder DOB:_____ **SSN#**_____

Secondary: _____ **ID#**_____
Group#_____ **Policy Holder Name:**_____
DOB:_____ **SSN#**_____

Preferred Pharmacy:_____ **PH#** _____

Person(s) we can speak to on your behalf regarding your health/billing
Information: Name:_____ **PH#**_____
Name:_____ **PH#**_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier of all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Any fees incurred if your account is referred to a collection agency will be the responsibility of the patient.

Signature:_____ **Date:**_____

Patient History Form

Past Medical History

Previous Physician:_____ Date of last exam:_____

Allergies:_____

Hospitilizations:_____

Last Tuberculosis (TB) Screening:_____ Results:_____

If positive TB screen, date of last chest x-ray:_____ Results:_____

Have you ever had a sexually transmitted disease?_____
Diagnosis:_____

Which of the following conditions are you currently being treated or have been treated fo in the past (please check all that apply)

__ Heart Disease/ Murmur/ Angina __ Shortness of Breath __Diabetes
__ Eye Disease/ Glaucoma __High Cholesterol __ Asthma __Seizures
__ Kidney/Bladder Problems __ High Blood Pressure __ Lung Problems/Cough
__ Stroke __Low Blood Pressure __Liver Problems/ Hepatitis __Cancer
__ Sinus Problems __Headaches/ Migraines __Arthritis __Heartburn (reflux)
__ Seasonal Allergies __Neurological Problems __Anemia or Blood Disorders
__Tonsillitis __Depression __Anxiety __Ulcers/ Colitis __Swollen Ankles
__Ear Problems __Psychiatric Care __Thyroid problems

Please describe any current or past medical treatment not listed above:

_____

_____

Please list past surgeries:

_____

_____

Medications:

_____

_____

_____

_____

_____

_____

_____

Social and Preventative History:

Do you smoke?_____ If so, How Many Packs per Day:_____

Do you drink caffeine?_____ If yes, How many cups per day_____

Do you drink alcohol?_____ If yes, how many drinks per week_____

Family History

	Living	Age(or age at death)	List serious Illnesses
Mother	__Yes __No	_____	_____
Father	__Yes __No	_____	_____
Sisters	__Yes __No	_____	_____
	__Yes __No	_____	_____
	__Yes __No	_____	_____
Brothers	__Yes __No	_____	_____
	__Yes __No	_____	_____
	__Yes __No	_____	_____

Has any member of your family(including children and parents) had any of the following

Illness	Which family member
Anemia or Blood Disorder	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart Disease	_____
High Blood Pressure	_____
HIV Disease/ AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other Serious Illness	_____

Females: Gynecological History

How many times have you been pregnant? _____ Last Pap Smear: _____

Have you had an abnormal Pap Smear?_____ Diagnosis:_____

Date of last Mammogram:_____ Results:_____

Have you ever had a breast biopsy?_____ Results:_____

By signing below , I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete. true, and accurate.

Patient/ Legal Guardian Signature_____ **Date:**_____

FINANCIAL POLICY

Thank you for choosing Robert Samaan, M.D., Inc. as your health care provider. The following is a statement of our Financial Policy which we require you to read, agree to and sign prior to any treatment.

All patients must complete and sign our new patient packet before seeing the physician or nurse practitioner. The "Patient Information Sheet" must be updated yearly or with any change. It is your responsibility to notify the office of any change of address, phone number or insurance carrier. Please remember that it only take a few moments of your time to keep necessary information current and correct!

Medicare: Robert Samaan, M.D., Inc accepts Medicare assignment. Medicare pays 80% of its approved amount after the yearly deductible. This leaves a 20% balance as the responsibility of the member. Insurance carriers offer Medicare subscribers secondary coverage which will pay all or part of this remaining balance.

Medicaid: Your Medicaid card must be presented to the receptionist EVERY time you visit our office or your visit may be rescheduled.

Managed Care & Commercial Policies: All co-payments are due at check in. There will be a $5 charge per date of service for any co-pay not paid on the date of service. It is considered the patient's responsibility to know the amount of their co-pay and when it is required by their insurance carrier. Whether or not the patient is asked for the payment is not an indication of responsibility.

Additional charges: Returned check fee $20
Missed appointment--office visit $36
Missed appointment--testing $50
Form fee $10/page

Patient balances are due 30 days from statement date. Past due balances will be referred to our collection agency. All fees incurred with collection agency will be the patient's responsibility. Please speak to someone in our billing department if you need to make payment arrangements.

Credit balances under $25 will not be returned without a written request after 3 years.

I have read and understand the Financial Policy

Patient Name _____ Date _____

Responsible Party _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Patient Name: _____
Medical Record #: _____
Date of Admission: _____

By signing this form, you acknowledge that Robert G. Samaan, M.D. has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have received Robert G. Samaan, M.D.'s Privacy Notice.

[ ] Robert G. Samaan, M.D. has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____
Patient's Signature Date

Robert G. Samaan, M.D.'s staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgement form and Robert G. Samaan, M.D.'s efforts in trying to obtain the patient's signature:

_____
_____
_____
_____

PATIENT PRIVACY RIGHTS

Policy

It is the policy of Robert G. Samaan, M.D. to implement the following policies and procedures that will ensure patient privacy rights in accordance with the Privacy Regulations promulgated under HIPAA:

1. **Availability of Robert Samaan, M.D.'s Privacy Notice.** The patient has the right to receive our privacy notice in a timely manner. Upon request, the patient may at any time receive a paper copy of our privacy notice, even if he or she earlier agreed to receive the notice electronically. We must also post our privacy notice in a prominent location.

2. **Requesting restrictions on certain uses and disclosures.** The patient has the right to object to, and ask for restrictions on, how his or her health information is used or to whom the information is disclosed, even if the restriction affects the patient's treatment or our payment or health care operation activities. The patient may want to limit the health information that is included in patient directories, or provided to family or friends involved in his or her care or payment of medical bills. The patient may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to the patient's requested restriction.

3. **Receiving confidential communication of health information.** The patient has the right to ask that we communicate his or her health information to them in different ways or places. For example, the patient may wish to receive information about their health status in a special, private room or through a written letter sent to a private address. We must accommodate requests that are reasonable in terms of administrative burden. We may not require the patient to give a reason for the request.

4. **Access, inspection and copying of health information**. With a few exceptions, patients have the right to inspect and obtain a copy of their health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge the patient a reasonable fee for copies of their health information.

5. **Requesting amendments or corrections to health information**. If the patient believes their health information is incomplete or incorrect, they may ask us to correct the information. The patient may be asked to make such requests in writing and to give a reason as to why his or her health information should be changed. However, if we did not create the health information that the patient believes is incorrect, or if we disagree with the patient and believe his or her health information is correct, we may deny the request. We must act on the request within 60 days after we receive it, unless we inform the patient of our need for a one-time 30-day extension.

6. **Receiving an accounting of disclosures of health information**. In some limited instances, the patient has the right to ask for a list of the disclosures of their health information that we

have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must furnish the patient with a list within 60 days of the request, unless we inform the patient of our need for a one-time 30-day extension, and we may not charge the patient for the list, unless the patient requests such list more than once in a 12 month period. In addition, we will not include in the list disclosures made to the patient, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

7. **Complaints**. Patients have the right to file a complaint with us and with the federal Department of Health and Human Services if they believe their privacy rights have been violated. We will not retaliate against the patient for filing such a complaint. To file a complaint with either entity, the patient should contact Linda Wunderlich, the Privacy Officer, who will provide the patient with the necessary assistance and paperwork.

Procedures

1. Should the law regarding patient privacy rights under HIPAA change, we will update our organization's policies and procedures regarding those rights, if applicable.

2. All new staff of Robert Samaan, M.D. shall receive a copy of this document at employee orientation and be directed at orientation as to how to access more detailed privacy policy and procedure documents.

3. All current staff of Robert Samaan, M.D. shall receive a copy of this document as part of our HIPAA compliance training session, and upon request.