Avicenna Medical Center
709 Bagdad Road
Leander, TX, 78641

www.avicennamedicalcenter.com
Tel. (512) 260-0101
Fax (512) 260-0121

Internal Medicine

Date:_____

Patient Information

Last Name:_____ First Name:_____ Middle Initial: _____ Sex: ____

Date of Birth: ____/____/____ Social Security Number: _____-_____-_____ Home Phone: (____) ____-_____

Address:_____ Apt. #_____

City:_____ State: _____ Zip Code:_____

Additional Information

Email:_____

Home Phone: (____) ____-_____ Work: (____) ____-_____

Cell: (____) ____-_____ Other: (____) ____- _____

Employer: _____

Employer Address:_____

Employer Phone: _____

Emergency Contact Name: _____

Relation to Patient: _____

Phone Number: _____

Patient's Marital Status:
Single ___ Married ___ Separated ___ Divorced___ Widowed___

PATIENT'S:
Spouse's Name:_____

Spouse's Date of Birth: ____/____/_____

Insurance Information

Primary Insurance

Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Policy #:_____ Group #:_____

Policyholder:_____

Secondary Insurance

Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Policy #:_____ Group #:_____

Policyholder:_____

CONSENT TO TREAT – Please read carefully

Patient Name: _____ DOB: _____

CONSENT FOR TREATMENT

I hereby authorized evaluation and treatment by the physicians and staff associated with Avicenna Medical Center. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

_____

Patient (Please Print)

_____ _____

Patient (Signature) Date

FINANCIAL POLICY– Please Read Carefully

- Copayment, deductible or coinsurance is due at the time of service. We accept Cash, MasterCard or Visa.

- Any balances that are applied to your deductible must be paid in full before the next office visit.

- **WE DO NOT ACCEPT CHECKS.**

- ***2 business day prior notice of appointment cancellation is required***. A **$50.00** cancellation fee will apply after the second cancellation that does not meet our requirements. A **$100.00** cancellation fee will apply after the third cancellation that does not meet our requirements.

- Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be turned into collections, and additional fees will be assessed.

- If your balance is high, due to hospital deductible or financial hardship issues, please meet with the office manager to establish a payment plan option.

- For private pay families, we offer a cash rate discount. Please contact our office for cash rates. **All balances must be paid in full at the time of the service. Please note: NO CHECKS ACCEPTED.**

- **A $25.00 charge for medical records must be paid at the time the records are requested.**

Please note: There will be a charge for after hours calls. The charge will be **$20.00 billed directly to the patient**. This fee is not covered by any insurance plan.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient Name (Signature) Date

INSURANCE AUTHORIZATION – Please read carefully

INSURANCE INFORMATION

- As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.
- We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information.
- We will not be responsible for any denied claims due to filing deadlines if new insurance is not presented to us at the time of service.
- Prior to the office appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.
- It is advised that all patients verify (if not already known) to see if we are a network provider for your insurance.
- Check which lab your insurance company is contracted with.
- Our clinic holds an additional stock of state mandated immunizations available for your child free of charge if you meet the criteria of being underinsured. A $5.00 charge per vaccine administration will apply.

AUTHORIZATION

As a courtesy, Avicenna Medical Center will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Avicenna Medical Center and/or the rendering physicians(s) to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Avicenna Medical Center. This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

Patient Name (Please Print) Signature Date

. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Irene Gonzalez at (512) 260-0101 or manager@amcemail.com for further information about the complaint process.

This notice was published and becomes effective on April 21, 2008. If you wish to have a copy of this document for your records, please ask the front desk staff to print you a copy. You may also download a PDF version of this document from our web site: www.avicennamedicalcenter.com

I hereby acknowledge the receipt of "Avicenna Medical Center Notice of Privacy Practices, Version I" and agree to the terms and conditions stated in this document:

This is the only the last page of the Notice of Privacy Practices. If you would like to have a copy of all pages, please let us know or visit our website.

Date of Birth: _____

_____ _____
Patient's Name (Please Print) Date

_____ _____
Patient's Name (Signature) Date