WESTCHASE HEALTH AND MEDICAL WEIGHT LOSS CLINIC

PATIENT INFORMATION Page 1

NAME: ____ DATE OF BIRTH: __________________
Last First Middle Initial

SSN: _________ / _________ / _______ SEX: ☐ M ☐ F MARITAL STATUS: ☐SINGLE ☐MARRIED ☐OTHER

ADDRESS: ____ APT. # ____________________

CITY: ____ STATE: _______ ZIP: _____________

HOME PHONE: (______) ________- _______________ WORK PHONE: (______) _________ - ________________________

MOBILE PHONE: (______) ________- _______________ EMAIL ADDRESS: ____

EMERGENCY CONTACT: _________________________ RELATIONSHIP: _________________ PHONE: ________________

PATIENT'S EMPLOYER: ___________________________ EMPLOYER'S PHONE: _____________________________________

EMPLOYER'S ADDRESS: _________________________ CITY: ____________ STATE: _________ ZIP CODE: ____________

REFERRED BY: ____

PHARMACY PHONE: _______________ PHARM. FAX: ___________________ PHARM. ADDRESS: ___________________________

INSURANCE SUBSCRIBER ☐ SELF PAY **(IF YOU ARE THE INSURANCE SUBSCRIBER FILL IN YOUR SPOUSE'S INFORMATION HERE)**

PATIENT RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ CHILD

NAME: ____ DATE OF BIRTH: __________________
Last First Middle Initial

SSN: _________ / _________ / _______ SEX: M: ☐ F: ☐

ADDRESS: ____ APT.# ________________

CITY: ____ STATE:_______ ZIP:_____________

HOME PHONE: (______) ________- _________________________ MOBILE PHONE: (______) _________ - ________________

EMPLOYER: ____ WORK NUMBER: (_______) _______ - ________________

PRIMARY INSURANCE

INSURANCE CO. NAME ______________________________________ PLAN TYPE _____________ GROUP #______________

INSURANCE CO. ADDRESS ___________________________________ CITY _______________ STATE _____ ZIP _____________

SUBSCRIBER NAME ____ MEMBER ID # __________________ DOB _____________

EMPLOYER ___________________________________ ELIGIBILITY PHONE #________________________ EFF.DATE _____________

SECONDARY INSURANCE

INSURANCE CO. NAME ______________________________________ PLAN TYPE _____________ GROUP #________________

INSURANCE CO. ADDRESS ___________________________________ CITY _______________ STATE _____ ZIP _____________

SUBSCRIBER NAME ____ MEMBER ID # __________________ DOB _____________

EMPLOYER ___________________________________ELIGIBILITY PHONE #____________________________ EFF. DATE _________

ACKNOWLEGEMENT OF FINANCIAL RESPONSIBILITY

All Co pays, Coinsurance and Deductibles are due at the time services are rendered. We bill your insurance company for professional Services on your behalf as a courtesy and convenience for you; however this office does not accept responsibility for collecting your insurance proceeds or for negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included. The office bills the Insurance company appropriate billing codes compatible with the presentation and desires of the Patient at the time of the visit. These codes cannot and will not be changed later, to facilitate payments. Combining a sick office visit with a Routine Yearly Physical can cause problems with Insurance Payments and we discourage patients from doing this, unless deemed necessary by the physician.

Signature: ____ Date: ____

ASSIGNMENTS OF BENEFITS

I assign all direct payments from Medicare, Private Insurance and other Health Plans to be made to Tanveer Syed, M.D., P.A. for any and all medical services provided.

I authorize Tanveer F. Syed, M.D., P.A. and her staff at Westchase Health and Medical Weight Loss Clinic to release any information obtained in the course of my treatment to my insurance company, employer, or third party payer, governmental agency as required for filing claims, quality assurance, health plan administration, public health and complaints follow-up. **I have received and understand the Notice of Privacy Practices.**

PATIENT/GUARANTOR SIGNATURE:____ DATE:________

ACCESS TO PATIENT PORTAL

The email address that you have provided will be the one where your visit reminders and messages are sent to. Also when that email address is keyed in, to web enable you; the owner of the email has full access to your medical record through a secure patient portal. So as a respect to patient privacy, and to be in compliance with HIPAA Law do not give an email that belongs to someone else. If you still desire to use someone else’s email address, please sign the release below.

I wish to use the following email address____, that belongs to my

____________________________, who is my ______________________(relationship) and I understand that this

Person will have full access to my personal private information through my patient portal and I give my consent to release this information to him/her. I understand Westchase Health and Medical Weight loss Clinic will not be liable for any breach of Patient Privacy in this instance.