New Patient Registration Form

1 25982 Pala, Suite 140, Mission Viejo CA 92691
Tel: (949) 407-4404 , **Fax:** (949) 407-4647

2 16305 Sand Canyon Ave.
Suite 220 Irvine, CA 92618

Hosseini MD Medical Inc.
Endocrinology, Diabetes, and Metabolism

Welcome to our office. We are committed to providing high quality, comprehensive specialty care. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Date: .....

Patient Name: ..... Date of Birth: ..... Age: ..... Sex: ☐ M ☐ F

Parent if Patient is a Minor: .....

Social Security Number: ..... Marital Status: ☐ Married ☐ Single

Home Address: ..... City: ..... State: ..... Zip: .....

Home Telephone Number: ..... Work Telephone Number: .....

Cell Phone Number: ..... E-mail: .....

Occupation: ..... Employer's Name: .....

Primary Physician's Name: ..... Telephone Number: .....

Address: .....

Referring Physician's Name: ..... Telephone Number: .....

Address (If different than PCP): .....

NOTIFY IN CASE OF EMERGENCY

Name: ..... Relationship: .....

Cell Phone Number: ..... E-mail: .....

Address (If different than Patient): ..... City: ..... State: ..... Zip: .....

FINANCIAL INFORMATION

Person Responsible for Fees (if different than patient):

Name: ..... Telephone Number: .....

Address ..... City: ..... State: ..... Zip: .....

Insurance Information

Primary Insurance Company Name: ..... Insurance ID No. : .....

Secondary Insurance Company Name: ..... Insurance ID No. : .....

Subscriber's Information (if different than patient):

Subscriber's Name: ..... Subscriber's DOB: .....

Subscriber's SSN No.: .....

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Please Read Our Financial Policy Statement and Agreement on Reverse Medical Payments

I hereby certify that all the information I have reported to your office with regard to insurance coverage is correct, and authorize all payments of medical insurance benefits be paid to this Endocrine and Diabetes office for services rendered. I hereby authorize the release of any necessary information including Individually Identifiable Health Information (IIHI) for any related claim to my insurance carrier, (or, in the case for Medicare or Medicaid to appropriate authorities). I understand and agree that I am financially responsible for charges not paid by insurance company. Any payments for services rendered will be made in a prompt manner. A copy of this authorization may be used as the original.

Authorization of Release to Others

I am hereby giving permission to staff and employees of this Endocrine and Diabetes office to leave medical information on my answering machine at my residence/ cell phone or use text massage, e-mail or fax to communicate with me or may contact my family members/ individual listed below when I am not available. This information could be regarding the results of laboratory tests, radiological reports, medication changes, recommendations or urgent matters. The following is the name of the Family member or Individual who may receive the information: .....

Relation: ..... Phone No.: .....I further understand that I may revoke this authorization at any time. This must be in writing to the healthcare provider with an effective date and no retroactive dates will be accepted. Please initial.: .....

Consent Agreement and Privacy Notice

It is our policy to obtain a signed consent from all of our patients as it relates to the use and disclosure of their Individually Identifiable Health Information (IIHI). The law requires we inform you of our policy regarding the protection of your IIHI through our Privacy Notice, which we will provide you. In the notice you will find full explanation of how our office will accomplish this. The following statement allows us the necessary latitude to work within the requirements. I have been presented with a Privacy Notice explaining my rights regarding my IIHI (individually identifiable health information). I consent to the use and disclosure of my IIHI for purposes of treatment, payment or other health care operations. Additional uses of my IIHI will require an authorization from me for the specific intention of disclosure. Please initial.: .....

We provide electronic prescriptions to all pharmacies online. With the exception of emergencies, prescription refills should be faxed into our offices by your pharmacy 72 hours in advance. If you participate with a mail away pharmacy, your new prescriptions will be sent either electronically or by fax, or provided to you directly. Please allow adequate time for the new prescription to reach you.

Upload Documents:

DL. | Insurace Cards(front & Back) | lab. Report | Radiology Report | other (Web Site Onley)

Please sign that you have read and understand the above

Patient Name: ..... Parent's Name If Patient is a Minor: .....

Patient Signature: ..... Date: .....

Financial Agreement:

1. Hosseini MD Medical Inc. will file for insurance benefits and accept payments according to contractual agreements with participating insurance companies. Any dispute or questions concerning insurance coverage or payment of benefits is a matter between the policyholder and the insurance company.
2. Referrals and Authorizations: I understand that it is my responsibility to contact and obtain from my insurance plan any referrals, pre-certifications or authorizations prior to receiving any non-emergency medical services from HMI. If a referral is required and I do not bring it with me, my appointment may need to be rescheduled. I accept full responsibility of all charges and fees billed by HMI if a referral is required and I do not provide one.
3. I understand that I will be responsible for payment of "non-covered" or "incidental" services related to patient care, including but not limited to telephone and/or email consultations, prescription refills not done at the time of service, dietary instruction or diabetes education not covered by my insurance policy or other medical care requested.
4. I understand there will be a charge for copying medical records, letters or any medical forms which need to be completed by the physician.
5. **I agree to pay a $25.00 fee for any missed appointments not cancelled twenty-four (24) hours prior to the scheduled appointment.**
6. **I understand that I will be billed for any balances which arise due to insurance co-payments, co- insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependent to insurance plan, non-payment at time of service and/or any other reason and agree to pay all charges within thirty (30) days of the billing date.** Interest of one and one-half percent (1.5%) per month, eighteen percent (18%) per annum, may be charged on all delinquent accounts over sixty (60) days.
7. If the balance is not paid within sixty (60) days of the billing date, or if agreed upon payment arrangements on my account are not made, HMI may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. I understand that I will be responsible for all additional fees incurred from that attorney and/or collection agency.
8. I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fees for services.
9. I certify that the information I have provided to HMI with regard to my insurance coverage is correct and agree to immediately inform HMI of any changes in my personal demographic information, address, e-mail and, telephone number (s), or insurance coverage.
10. I understand that I will not get prescription refills if I miss a follow up appointment.
    If found appropriate by my physician, I will only receive enough of a particular medication to cover me until the next scheduled appointment.

Patient's name: ..... Signature: ..... Date: .....

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MEDICATION RECORD

Please write the name, dosage and frequency of all medications you are currently taking

MEDICATION NAME	DOSAGE	FREQUENCY

Name of pharmacy: ..... Phone number: .....

Pharmacy Address: .....

Past Medical History

1. .....
2. .....
3. .....
4. .....
5. .....

Past Surgical History

1. .....
2. .....
3. .....

ALLERGIC REACTIONS TO DRUGS

☐ No known allergy

1. .....
2. .....
3. .....