PATIENT REGISTRATION FORM

Date:_____ Email:_____

PATIENT INFORMATION: (Please use full legal name)

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone#:_____Cell Phone#:_____

DOB:_____ Sex:F/M Marital Status:_____ Social Security#_____

Employer Name and Address:_____ Work Phone:_____

Emergency Contact/Relationship:_____ Emerg Phone #:-_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill-use full legal name)

Relationship to patient: Self_____ Spouse_____ Parent_____ Other_____

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone#:_____Cell Phone#:_____

DOB:_____ Sex:F/M Marital Status:_____ Drivers Lic#_____

Employer Name and Address:_____ Work Phone:_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance

Plan Name:_____ Policy Holder:_____

Policy Holder SS #:_____ Policy Holder DOB:_____

Policy ID #:_____ Group #:_____ Eff Date:_____

Claims Address & Phone Number:_____

Secondary Insurance

Plan Name:_____ Policy Holder:_____

Policy Holder SS #:_____ Policy Holder DOB:_____

Policy ID #:_____ Group #:_____ Eff Date:_____

Claims Address & Phone Number:_____

Financial Policy

Thank you for choosing Highlands Medical Associates as your healthcare provider. We are committed to providing you with quality, affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this. Please review and ask us any questions you may have.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

3. Non-covered services. Please be aware that some or all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit and a signature is required from you prior to services being rendered.

4. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. The staff at Highlands Medical Associates understands that certain circumstances require rescheduling of an appointment. However, three or more "no shows" may result in a patient being discharged from the provider. A "no show" is defined as when a patient misses an appointment and has not called prior to the appointment time to reschedule, or is more than 15 minutes late. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. A charge of $35.00 may be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

* Medicare recipients are exempt from the missed appointment charge.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Date:_____

Patient Signature:_____ Printed Name:_____

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth:_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____.

Signed: _____ Date: _____

Witness:_____Date:_____

Dallal W ABDELSAYED, M.D.
PATIENT HISTORY QUESTIONNAIRE

Name: _____ *DOB:*_____ *SSN:*_____
*Signature:*_____ *Today's Date:*_____

In order for us to better serve you, we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for you own health! Thank you.

Please list and describe your symptom, problem, condition, diagnosis or other factor that is the reason for your visit to this clinic today: _____

Are your symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No
If you answered yes, please fill out accident specific form, available at the front desk.

Please describe in detail how your present illness / symptoms developed / started (suddenly or gradually) from first sign and / or symptom to the present (including location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms, etc.)

_____

_____

Describe the quality / character of your symptom (s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc._____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>>	Numbness ======	Pins and Needles ↓↓↓↓↓↓	Burning ××××××
Stabbing ∇∇∇∇∇	Throbbing ~~~~~~	Tingling ++++	Sharp ↔↔↔↔
Dull 00000	Soreness ∩∩∩∩∩	Shooting ⊕⊕⊕⊕	Other

On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Severe Pain

What is your least pain/discomfort? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Severe Pain

What is your worst pain/discomfort? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Severe Pain

How much time during an average day are you in pain/discomfort?

Less than 1 hour per day
Between 1 and 4 hours per day
Between 4 and 8 hours per day
Almost anytime when not lying down
Almost 24 hours per day
Other_____

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Have you ever been involved in injuries from following: Yes No

If yes, please list all of them with date, type, and legal status
Automobile accident Worker's Compensation Personal injuries someone else legally liable for (slip and fall, etc.)

Injury	Date	Settled	Not settled	Attorney's Name & Address

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and how long you have taken it.

Medication	How often	How much	For how long

Are you allergic to anything (medications, lotion, etc.)? YES NO
If yes, to what? _____

Who is filling out this questionnaire? Self Spouse
Other_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Name (print) _____Signature_____ Date_____

Physician's Signature (upon review) _____
Date_____

Highlands Medical Associates, P.A.
Dallal W. Abdelsayed, M.D.
607 E. Wallisville Rd, Highlands, TX. 77562
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What made your current symptoms better or worse? _____

Is your sleep disturbed by these symptoms? YES NO Slightly Moderately Severely

Have you experienced any restrictions or difficulties in any ACTIVITIES OF DAILY LIVING, SOCIAL and RECREATIONAL ACTIVITIES because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) YES NO
Slightly Moderately Severely

_____
_____
_____

Have you experienced any restrictions or difficulties in performance of your JOB DUTIES at work because of your current condition, please describe in detail YES NO
Slightly Moderately Severely

_____
_____
_____

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic? YES NO
If yes, please list each doctor individually. (for more than one doctor, use additional space to list them)
If yes, whom did you see? Doctor's Name:_____
Specialty:_____
Address:_____City_____State_____
Phone_____ When were you seen? From _____to_____

Are you still under this doctor's care? Yes No
Were X-ray MRI CAT Scan EMG Bone scan or others_____ taken?

What was diagnosis? _____

What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others) _____

How much were your symptoms/discomforts improved or helped? Please circle.
No improvement 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 Full improvement

Since your symptoms began, were they (improved worsened stayed the same)?

Please list your past experiences with illnesses, operations, injuries and treatments);

Illness/injury	Date	Recurring

Are there any medical events in your family, including diseases which may be hereditary or place you at risk YES No
If yes, please explain:

_____
_____