Patient Information

Dr. Syed Gilani, M.D., F.A.C.P.
237 E. Baldwin Road Suite #101
Panama City, Fl., 32405

Phone: (850) 215-5885 Fax: (850) 215-5890

Name : _____

SEX: M/F D.O.B : _____ **S.S #** _____

Home Phone: _____ **Cell Phone:** _____

Email : _____

Physical Address: _____

_____

Mailing Address (if Different) : _____

_____

Emergency Contact Name and Phone Number: _____

_____

INSURANCE ASSIGNMENT OF BENEFITS & PAYMENT POLICY

I request that payment of authorized Medicare and/or Medical Insurance benefits whether primary or secondary benefits be made on my behalf to Syed Gilani, M.D. for any services furnished to my. I authorized Syed Gilani, M.D. to furnish any of my insurance companies and/or its agents all medical records necessary to determine benefits for services provided to me. I understand that I am financially responsible for charges when services are rendered and that payment of deductibles and coinsurance are required at the time of serviced for all services.

Patient Signature: _____ **Date :** _____

Primary Insurance : _____ **Second Insurance :** _____

(WE HAVE TO HAVE COPIES OF ALL INSURANCE CARDS IN ORDER TO FILE CLAIMS FOR YOU)

Name_____ Today's Date_____

☐ Male ☐ Female Age_____ Birthdate_____ (mm / dd / yyyy) Date of last physical examination_____

Marital status_____ Occupation_____

What is the reason for your visit today?_____

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
_____Menstrual period	_____Cholesterol testing	_____Pneumonia vaccine	_____Digital rectal exam
_____Mammogram	_____Colonoscopy	_____Bone Density (DEXA)	_____PSA (prostate blood test)
_____Pap smear	_____Tetanus booster		

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type _____	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema/COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections

☐ Other _____

ALLERGIES? *Check ☑ appropriate box below. If yes, please list all known allergies to medications or substances*

☐ No known allergies ☐ Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check ☑ appropriate boxes below and describe*

Caffeine	☐ None	☐ _____ drinks per _____	
Tobacco	☐ None	☐ _____ cigarettes per day	☐ Quit smoking around _____
Alcohol	☐ None	☐ _____ drinks per _____	
Drugs	☐ None	☐	
Diet	Describe:		
Exercise	Describe:		
Seat belts	☐ Always	☐ Never	☐ Sometimes

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications, if any

PREGNANCY HISTORY

pregnancies_____; # living children _____

deliveries: C-sections_____; vaginal _____

Birth year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

Have you ever had a blood transfusion? ☐ No ☐ Yes Date(s):

FAMILY HISTORY

Fill in information about your family below:

Relation	Age, if living	Age at death	Medical conditions / cause of death
Father			
Mother			
Brothers			
Sisters			

Check ☑ if a blood relative has had any of the following:

Disease	Relationship to you
☐ Arthritis	
☐ Asthma	
☐ Cancer	
☐ Diabetes	
☐ Gout	
☐ Heart disease	
☐ High blood pressure	
☐ Kidney disease	
☐ Stroke	
☐ Other	

ADDITIONAL INFORMATION *What else do you think your doctor should know about your health?*

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ Reviewed by_____ Date_____

Our financial policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, MasterCard, discover, and American Express.
2. Keep in mind that you insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment, If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the isurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party,if minor) Date

Please print the name of the patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 1, 2013 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices providing law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the data changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Penny Gilmore. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose your health information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to make reasonable inferences of your best interest be allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We will use and disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, including, but not limited to, voicemail messages, postcards or letters.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee Signature Date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only Federal, not State, law.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DR. SYED GILANI, M.D.
237 E. BALDWIN ROAD SUITE 101
PANAMA CITY, FL 32405
PHONE: (850) 215-5885 FAX: (850) 215-5890

Patient

Date_____

Last Name First MI

Address

Account Number

City State Zip

Date of Birth

Authorizes:

Name of Health Care Provider

Address

City State Zip

Information to be Released:

Purpose of Disclosures:
(Check Applicable Categories)

☐ All Records ☐ Labs

☐ Medical History, Examination, Reports

☐ Other (Specify) _____

☐ Further Medical Care

☐ Changing Physicians

☐ Other (Specify) _____

Patient's Rights With Respect to This Authorization

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the business office of Dr. Syed Gilani. I understand the revocation will not apply to information that has already been released prior to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire on the following date, event, or condition:_____

If I fail to specify an expiration date, event, or condition, this authorization will expire three (3) years from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Endocrine Medicine Associates Privacy Officer.

Signature of Patient or Legal Representative Date

IF SIGNED BY A LEGAL REPRESENTATIVE:

Relationship to Patient Witness Signature

Description Of Authority To Act For Patient

SYED GILANI, M.D., F.A.C.P.
Internal Medicine

237 E. Baldwin Rd., Suite 101
Panama City, FL 32405
Telephone: (850) 215-5885
Fax: (850) 215-5890

CANCELLATION POLICY / NO SHOW POLICY

Dear Patient,

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you are preventing another patient from being seen in that spot for much needed treatment.

Effective June 1, 2018, if a confirmed appointment is not cancelled at least 24 hours in advance you will be charged a twenty five ($25.00) fee; this will not be covered by your insurance. This charge will have to be paid in full before your next appointment.

You will receive a letter alerting you to the fact that you failed to show up for an appointment and a statement for the charge. Continued "no shows" will result in review for potential discharge from the practice.

PRINT PATIENT NAME _____ PATIENT SIGNATURE/GUARDIAN _____ DATE _____

DR. SYED GILANI
237 E. BALDWIN ROAD, SUITE 101
PANAMA CITY, FL 32405
PHONE: (850) 215-5885 FAX: (850) 215-5890

PLEASE FILL OUT ONLY IF YOU WANT TO GIVE PERMISSION FOR OUR DOCTOR TO DISCUSS YOUR RECORDS WITH ANY ONE OTHER THAN YOURSELF.

I _____ GIVER PERMISSION TO DR. GILANI TO DISCUSS ANY AND ALL OF MY RECORDS WITH MY FAMILY MEMBERS LISTED HERE.

1._____

2._____

3._____

4._____

5._____

PATIENT SIGNATURE _____

WITNESS _____

DATE _____