

# MEDICAL ART CENTER | COVID PATIENT REGISTRATION

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Name	Last	First	MI	
Street				
City	State	Zip		
Home Phone	Email			
Cell Phone	Birthdate	/ /	Age	
Gender	<input type="checkbox"/> Male	Employer		
	<input type="checkbox"/> Female			
Race	Work Phone			
Soc Sec #	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	
Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Pharmacy	Phone			
Emergency Contact	Phone			
Referred By: Check All That Apply	<input type="checkbox"/> Friend	<input type="checkbox"/> Family	<input type="checkbox"/> Patient	
	<input type="checkbox"/> Facebook	<input type="checkbox"/> Doctor		<input type="checkbox"/> Healthgrades
	<input type="checkbox"/> Billboard	<input type="checkbox"/> TV	<input type="checkbox"/> Work	<input type="checkbox"/> Instagram

## PATIENT CONFIDENTIALITY (HIPAA)

### Acknowledgment of Receipt of the Notice of Privacy Practices

Name	Date of Birth
	Today's Date
<p>Patient confidentiality is one of our priorities and it is the law (HIPAA) implemented in 2003. Your privacy is a great concern in our office. Please indicate below with whom and where we may leave a message. When possible we try to confirm appointment as well as leave messages regarding medication, test results, and billing information.</p>	
<b>OUR OFFICE MAY LEAVE A MESSAGE AT</b>	
HOME   Yes   No	CELL   Yes   No
WORK   Yes   No	
<p>Due to our confidentiality requirements, should a family member, friend, or relative contact our office, please state who we have permission to discuss your condition/results with</p>	
Name	Relation
Name	Relation
Name	Relation
Name	Relation
Please provide your email address to receive office information?	
Please be advised that it is your responsibility to inform us if any changes should be made to the above information. Thank you.	

Date of Last Physical	
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CONFIDENTIAL FAMILY MEDICAL HISTORY							
	Alive	Age of Death	Present Health or Cause of Death		Alive	Age of Death	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
			Age of Living Children				

CHECK (✓) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY				
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression	<input type="checkbox"/> Allergies

MEDICATIONS and dosage you are currently taking, INCLUDE vitamins, herbs, supplements, etc.			

CHECK (✓) IF YOU ARE ALLERGIC TO			
<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Latex	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Local Anesthesia	<input type="checkbox"/> Sulfa

List any Allergies to medications or substances:

Do you take oral contraceptives?  No  Yes      Please list any of the following:

CHRONIC CONDITIONS	ACCIDENTS	DIAGNOSTIC TESTS
INJURIES/ILLNESSES	HOSPITALIZATIONS	SURGERIES

OTHER HEALTH CARE PROVIDERS		
Primary Care	OB/GYN	
Preferred Pharmacy		
	<b>Name</b>	<b>Location</b> <b>Number</b>

Living Will | Advance Directive?  No  Yes      May we have a copy for your chart?  No  Yes

**CERTIFICATION**  
 To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child every have a change in health.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative      DATE

\_\_\_\_\_  
 Please PRINT name of Patient, Parent, Guardian or Personal Representative

# MEDICAL ART CENTER | COVID REGISTRATION Part 2

## PATIENT DISCLOSURE OF NETWORK AND BILLING INFORMATION

Welcome to the Medical Art Center, LLC. We consider it a privilege to be selected as your health care provider. The following disclosure is made to inform you of billing matters pertaining to your care at this facility.

Please take notice that some physicians or diagnostic facilities, including but not limited to laboratory services, who are associated with this facility may not be participating providers with your insurance carrier. If the physician or facility is not a participating provider with your insurance carrier, then part or all of the medical services that you receive from the respective physician or facility will be considered "out-of-network". Services provided by out-of-network providers or facilities will be reimbursed by your insurance carrier at the out-of-network benefits level. This could mean that you may have additional out-of-network expenses not covered by your insurance carrier for which you will be personally responsible. Please do note that the information provided herein is for the out-of-network disclosure purpose only and is not a representation of insurance plan coverage.

The Medical Art Center, LLC is available at 732-888-0017 to discuss questions about your insurance plan coverage and related financial responsibility. You have the right to make informed decisions about your care including the right to make decisions concerning accepting, refusing or choosing from alternatives or medical and/or surgical treatments. You also have the right to utilize physicians or facilities not affiliated with Medical Art Center, LLC. A list of geographically convenient alternative physicians or facilities is available upon request. The physicians, nurses and the entire staff at Medical Art Center, LLC are committed to your care.

I, the undersigned, do hereby acknowledge and agree to the foregoing Billing Disclosures provisions.

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**Patient Name** **Date of Birth**

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**Please PRINT name of Patient, Parent, Guardian or Personal Representative (Relationship)** **Date**

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**Witness** **Date**

## CANCELLATION POLICY:

If you need to cancel a FOLLOW UP appointment, we REQUIRE a notice of 24 hours or a **\$50.00 fee** will be charged. If you need to cancel a PHYSICAL appointment, we REQUIRE a notice of 72 hours or a **\$75.00 fee** will be charged.

If you miss your appointment WITHOUT notifying the office, there will be a **\$75.00 fee**.

Special testing such as ECHO'S, ULTRASOUNDS AND NERVE STUDIES REQUIRE a notice of 72 hours or there will be a **\$50.00 fee**. If you miss your appointment for these procedures without notifying the office, the charge will be **\$100.00 fee**.

By signing this cancellation policy, you are AWARE of the fees associated with cancelling your appointment. You must notify the office according to the policy above. Failure to do so will result in a fee.

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**Patient Name** **Date of Birth**

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**Please PRINT name of Patient, Parent, Guardian or Personal Representative (Relationship)** **Date**

---

**Witness** **Date**

# MEDICAL ART CENTER | FINANCIAL POLICY

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

## PATIENT FINANCIAL POLICY

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

You hereby authorize insurance payment directly to our office. Should payment be sent to you, it is your responsibility to return the check to our office, within ten (10) days of receipt. Failure to do so will result in civil collection proceedings for the amount of the check(s) wherein you agree to pay all the interest, reasonable attorney, collection agency fees and costs incurred in collections. You further assign your rights to benefits under your contract of insurance of other third party payment to Medical Art Center, LLC and Shamra Medical Laboratory and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plans.

You hereby further provide Medical Art Center | Shamra Medical Laboratory with a limited irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually or jointly to you, Medical Art Center | Shamra Medical Laboratory. This power expressly authorizes third parties including but not limited to commercial banking institutions to honor our endorsements on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

You hereby authorize Medical Art Center | Shamra Medical Laboratory to pursue any means necessary to collect all charges on your account as assignee and/or you Designated Authorized Representative including follow up calls, appeals, arbitration, and civil suit, if allowable by law.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND THE HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION AS PATIENT UNDER THIS AGREEMENT.

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**Patient Name** **Date of Birth**

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**Please PRINT name of Patient, Parent, Guardian or Personal Representative (Relationship)** **Date**

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**Witness** **Date**

# MEDICAL ART CENTER | PATIENT DUTIES & AGREEMENT

I have sought the clinical and health care services of the Medical Art Center, LLC, for my personal healthcare or for my child(ren) who are minors. As a condition to treating at the Center, I agree as follows:

\_\_\_\_\_ **initial** Our office and its employees make no representations, claims or guarantees regarding the efficacy of our recommendations. The protocols we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information individualized protocols may be offered and applied as either adjunctive or primary protocols for certain conditions.

\_\_\_\_\_ **initial** You may be prescribed and or referred for diagnostic and/or consultations with healthcare providers or facilities not affiliated with the Medical Art Center, LLC. You agree and acknowledge that it is your responsibility as a patient to attend these referrals as well as follow up with the service provider concerning the results of such testing and/or consultations or other services. Medical Art Center, LLC, cannot do this for you and by signing this form you agree to assume this responsibility as a condition to treating at the Medical Art Center, LLC. It should not be assumed on the part of the patient that if they are not contacted by the Medical Art Center, LLC or its employees, or if the patient does not schedule or keep consultation, that test results are normal (or without abnormalities), and may not require further follow ups or advice. Health/medical recommendations and/or possible referral and additional follow up may be warranted based upon laboratory testing and evaluations. Patient hereby agrees to follow up directly with the third party provider of consultations and/or testing directly.

\_\_\_\_\_ **initial** Patient acknowledges and agrees that the Medical Art Center, LLC and/or Ammar

Bazerbashi, MD may refer or order testing but not perform interpretation of such testing, which is done by other licensed healthcare providers. Thus, patient acknowledges and agrees that the Medical Art Center, LLC and/or Ammar Bazerbashi, MD are not responsible for any such interpretations of testing and agrees to hold them harmless in this regard.

\_\_\_\_\_ **initial** In consideration for the services performed for the patient by Medical Art Center, LLC patient agrees to indemnify and hold harmless the Medical Art Center, LLC, its members, employees, agents and contractors from any and all liability arising from other healthcare providers that utilize the testing, records, or other information from patients' treatment and cause harm or damages to the patient.

\_\_\_\_\_ **initial** By signing this Agreement, you agree to hold harmless the Medical Art Center, LLC, its owners, employees, and contractors from all professional and personal liability, negligence, or other legal liability arising from you duties and agreements as a patient herein. You agree to be responsible for all legal costs and fees that may result from actions(s) on your part or on the part of your representative(s) against us. You have the right to have this agreement reviewed by your lawyer before accepting any services from our office and we suggest that you exercise this right.

\_\_\_\_\_ **initial** By signing this Agreement, patient also expressly agrees not to audio tape, video tape or otherwise record in any media any encounter with the staff or doctors at the Medical Art Center, LLC or at any time while on the premises of the Medical Art Center, LLC.

Name \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Medical Art Center is proud to be a comprehensive and all-embracing facility that promotes healing and wellness across the board. We go out of our way to offer our patients an extensive array of services and diagnostic studies/procedures for early diagnosis, prevention, and treatment of various ailments from mild to severe. **It is extremely challenging to house all of these procedures under one roof. However, we have been successful in providing our patients this courtesy and convenience.** If any of our providers/doctors orders a diagnostic procedure, and if your insurance permits, we will schedule it in our office.

\_\_\_\_\_ **If your insurance requirement is that the diagnostic studies/procedures be done at a specific facility, or IF YOU CHOOSE to have the diagnostic studies/procedures performed out of our office,**

we will **GLADLY** provide you a script to **the facility of your choice**, as well as the prior authorization information, if needed.

Keep in mind that undergoing these diagnostic studies/procedures will extend the duration of your visit. Furthermore, having your testing done at our facility will not incur you any additional cost to having them done out of our office.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

# SHAMRA MEDICAL LABORATORY | Insurance Waiver

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Name	DOB	Date
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## COVID TESTING

\_\_\_\_ (Initial) I am aware that my insurance may not cover the test. I am aware that if my insurance does not pay for the swab, I will be responsible for the cost of the test.

\_\_\_\_ (Initial) If I was told I had to pay a supplemental fee for my test, I am aware my insurance will be billed in addition to my fee, and that any collected fees are nonrefundable.

\_\_\_\_ (Initial) I am aware the Medical Art Center/Shamra laboratory offers the LIAT (PCR). The LIAT is not a single COVID test. This PCR tests for COVID-19 along with Influenza A & B.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If legal guardian what is the relationship to patient \_\_\_\_\_

## ANTIBODY TESTING FOR COVID-19

I am aware that my insurance will be charged for this testing.

If my insurance does not pay, I will be billed and responsible for approximately \$100.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If legal guardian what is the relationship to patient \_\_\_\_\_

# SHAMRA MEDICAL LABORATORY | Medical Release

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Name \_\_\_\_\_ DOB \_\_\_\_\_

Acknowledge that the Medical Art Management has released my medical records at my request to:

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_

**EMAIL directly to me – PRINT CLEARLY:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_