ALABAMA INFECTIOUS DISEASE CENTER, P.C.
420 LOWELL DRIVE, SUITE 301
HUNTSVILLE, AL 35801
(256) 265-7955

PATIENT REGISTRATION INFORMATION

☐ **Dr. Ali A.M. Hassoun** ☐ **Dr. Hafsa Hassan Siddiqui** ☐ **Dr. Zohra Chaudhry**

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Sex: _____ SSN #: _____

Marital Status (**S M W D**) Race:_____Language:_____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Patient's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

PRIMARY CARE DOCTOR:_____ **REFERRING DOCTOR:**_____

PHARMACY PREFERENCE: _____

EMAIL :_____**(allows access for patient portal information)**

BILLING INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Sex: _____ SSN #: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy Number: _____ Group #:_____
Subscriber Name: _____ Subscriber Sex: _____ Subscriber DOB:_____
Subscriber SSN #:_____ Subscriber Employer:_____

Secondary Insurance: _____ Policy Number: _____ Group #:_____
Subscriber Name: _____ Subscriber Sex: _____ Subscriber DOB:_____
Subscriber SSN #:_____ Subscriber Employer: _____

I/We, the undersigned, hereby agree to pay all amount and charges hereafter incurred by me and members of my family for services rendered by this office. I hereby authorize Alabama Infectious Disease Center to furnish information to insurance carriers concerning my illness and treatments. It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. I authorize benefits payable to the above physicians. I understand that I am responsible for any amount not covered by insurance. In the event of non-payment, either by insurance or mayself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessay to employ an attorney to enforce and provision of this contract. I/We further agree to waive my/our rights of exception under the laws of the State of Alabama or any other state.

Date: _____ **Signature:** _____

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MEDICARE PART B

EXTENDED PATIENT SIGNATURE AUTHORIZATION

TO BE COMPLETED BY PROVIDERS OF SERVICE-Please PRINT or TYPE

Provider's Name		Provider's I.D. Code
Provider's Address (Street, City, State, ZIP Code)		
Beneficiary's Name	Medicare HI Number	Applicable MEDIGAP Group Number

TO BE COMPLETED BY BENEFICIARY OR AGENT-Directions For Payment Of Benefits And Release of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS
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STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ or to _____ (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to _____ for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDICAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

✖ _____ ✖ _____
Signature of Beneficiary or person signing for Beneficiary — Date Signed

Address of Person Signing For Beneficiary (Street, City, State, ZIP Code)	Relationship Of Agent To Beneficiary
Reason Beneficiary Is Unable To Sign	

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment-event those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OF WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIER AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death of Institutionalization of the Beneficiary.

_____ _____
Signature of Durable Medical Equipment Supplier — Date Signed

INDIVIDUAL PATIENT'S AUTHORIZATION

ALABAMA INFECTIOUS DISEASE CENTER
420 LOWELL DRIVE, SUITE 301
HUNTSVILLE, AL 35801
PHONE: (256) 265-7955

Name: _____ **Date of Birth:** _____

I understand *that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.*
I understand *that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information policy laws.*

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations-and that the organization is not required to agree to the restrictions requested.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.

I understand *that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.*

I (the patient) am requesting that you, Alabama Infectious Disease Center, may release the following information regarding my health information to (Appointment Information, Medical Records, or Health Information):

- ***Please list the name of Person(s) to whom we may release information:***
  Name_____ **(Relationship to Patient)**_____
  Name_____ **(Relationship to Patient)**_____
  Name_____ **(Relationship to Patient)**_____

- ***Please identify the information that may be released to this person:***
  _____Appointment information _____Treatment Information _____Health Information
  _____Account Information _____All of the Above

- ***May we leave a message/contact you regarding:***

	Home Phone	***Work Phone***	***Cell Phone***
Appointments:	**Yes/No**	**Yes/No**	**Yes/No**
Lab Results:	**Yes/No**	**Yes/No**	**Yes/No**
Office Information:	**Yes/No**	**Yes/No**	**Yes/No**

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, of (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organization named in this form.

X_____ _____

Signature of Patient or Legal Representative *Date*

Office and Financial Policy

Thank you for choosing Alabama Infectious Disease Center, PC for your health care needs. In an effort to make your transition to our practice as smooth as possible we have the following policies that we request you read & sign. Please feel free to seek clarification on any of our policies.

Alabama Infectious Disease Providers:
Ali Hassoun M.D. Hafsa Siddiqui M.D.
Zohra S. Chaudhry M.D.

Patient Identification	All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a valid government issued picture ID and current valid insurance card. Without the requested ID, you may not be seen. 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. It is your responsibility to inform us of any address changes immediately.
Cell Phone Use	We ask that cell phones are not in use in the clinical areas.
Referrals and Authorizations	Please allow 5-7 business days for referrals/authorizations to be approved. Most plans do not allow retro-referrals. These are provisions you agreed to when you contracted or signed up with your insurance plan. When providing information to us to initiate a referral we will need providers name, phone number, location, and date of appointment. It is your responsibility to make sure a referral is active before seeing a specialist.
Medications & Prescription Refills	Each patient is asked to bring a list of all medication or all bottles currently being taken, *including over the counter medication*, with him/her to each visit. All prescription refills require a 24-48 hour notice to our staff to process. We prefer for our patients to call to request refills, or utilize the patient portal for these requests. Pharmacies will auto-fax requests when you do not need the medication or a dosage has been changed. If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit (two weeks maximum). It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next visit before you leave our office. ***We do not call in new prescriptions without being seen in office, including an antibiotic.*** ***If you are having problems with side effects, or need a change in dosage, please schedule an appointment to discuss problems and explore alternative options.*** ***Prior Authorizations for medications are done as a courtesy to the patient. This may require a trail of the preferred medication on your formulary prior to submission.***
After Hours and Emergency Care	Our providers are on call 24/ by calling our office at 256-671-0089 Please call our office prior to going to the emergency room for non-life threatening emergencies. Emergency rooms are properly staffed for critical situations and not for treatment of cold, flu sprains or chronic conditions. To provide better service to you SAME DAY appointments are now available Monday- Friday for our established patients.
Messages	We encourage patients to contact us through the patient portal for general questions or concerns. We strive to respond the same day. Non-urgent messages will be returned within 48 hours. If you have something that can't wait please call office number to leave message with office staff. If you call during lunch or after hours for a general questions please leave a message on our answering machine it will be returned with 48 hour for non-urgent messages.

Cancellation and Missed Appointments	Appointment times are an important commitment of reserved time for you and the physician/practice. Therefore missed appointments create an interruption for staff members and other patients on the schedule. Our office will attempt to call you within 24-48 Hours prior to your appointment and will leave a message for you to call us back to confirm. It is your responsibility to confirm with our office or if needed to cancel within **24 hours**. **Cancellation of Appointments:** We understand personal matters do occur that may necessitate a cancellation; therefore we ask kindly for at least a **24 hour** advance notification. **No Show to Appointments:** The definition of No Show is when a patient has a scheduled appointment and does not show up as scheduled and without cancellation notification to the office. **New Patients:** • 1st No Show- Office will notify patient by phone call and remind patient of no show policy. • 2nd No Show- Office will notify patient by mailing a final letter indicating termination of services. (Appointment will not be rescheduled) **Established Patients:** • 1st No Show- Office will notify patient by phone call and remind patient of no show policy. • 2nd No Show- Office will notify patient by mailing a letter and policy reminder. • 3rd No Show- Office will notify patient by mailing a final letter indicating termination of services. Termination of services will include a grace period of 30 days for prescription refills. It will be the patient's responsibility to find a new physician and contact his/her insurance carrier for assistance with finding another physician. ***All No Show Episodes are subject to a $50.00 fee.**
Late For Appointment	We understand natural unplanned events may cause you to run a little behind. A call in advance would be appreciated; however if you are greater than 15 minutes late when arriving to a scheduled appointment your appointment will be rescheduled.
Insurance & Payment Responsibilities	Payment is expected on the date of service. This includes self-pay patients and your coinsurance and co-payments responsibilities. Failure to do so will result in the rescheduling of your appointment. There will be a $35.00 fee charged for returned checks. Patients with an outstanding balance over 90 days that have not made a payment arrangement will be sent to collection, prevented from scheduling future appointments and discharged from the practice. Your account will then be turned over to a collection agency. Patients with manage care plans with an assigned provider will be responsible for making sure they have their referral in before see. You will not be able to be seen until this is complete and your appointment will be rescheduled. **It is the patient's responsibility for verifying and knowing his/her insurance coverage, deductible, co-payments, etc.**
Forms	A $25.00 charge per form fee will be charged for all forms completed in this office. Please note that some forms will require a face to face visit to be completed. Fees will be paid at time of service.
Medical Records	Copies of medical records are available upon request. A fee of $.25 cents per page will be charged for medical records provided to a patient. There is no fee of sending records to another provider.
Patient Dismissal	We have the right to terminate the patient relationship based on medical non-compliance, threatening or abusive behavior, failure to keep scheduled appointments and failure to pay as described in our dismissal policy.

I have read and understand the office policy and agree to abide by its guidelines:

_____

Patient Signature Date