AbbasiDerm.com
21401 Allen Road
Woodhaven, MI 48183
734.675.0835 Phone
734.675.0873 Fax

PATIENT INFORMATION
(please print)

Today's Date: _____/_____/_____

Name_____ SS#_____-_____-_____
Last First M.I.

Mailing Address_____
Street City State Zip

Home Phone: (_____) _____-_____ Cell Phone: (_____)_____-_____ Preferred #: H / C

Sex: ___ Female ___Male ___ Other Preferred Pronoun:_____ How would you like to be addressed?: _____

D.O.B_____/_____/_____ E-mail: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

GUARANTOR INFORMATION

Name_____D.O.B: _____
Last First M.I.

Mailing Address_____
Street City State Zip

Phone: (_____) _____-_____

EMERGENCY CONTACT

Name: _____

Phone: _____ Relationship to Patient: _____

HIPAA QUESTIONNAIRE

1. In signing this notice, I, _____am granting permission for this office to inquire or obtain information from my insurance company for treatment and billing purposes for myself and family members and to receive and/or forward necessary records if indicated in the case of a referral or transfer to another facility.

2. Please list the family members or other persons, if any, whom we may inform about your medical condition (including treatment and payment)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

3. Please list the family member who is named legal representative (guardianship, foster care or medical power of attorney), whom we may inform and/or inquire about your medical condition given more extenuating circumstances:

Name: _____ **Phone:** _____

4. Can confidential messages (i.e. appointment reminders) be left on your voicemail? Yes: ____ **No:** _____

CONSENT TO EXAMINATION AND TREATMENT

I understand and voluntarily consent to receive medical and health care services given by SAMI ABBASI, D.O., his associates or assistants. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations, and treatments considered advisable or necessary in the judgment of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my Dermatologist. I hereby release my examiner from all responsibility in connection with the examination.

CANCELLED, MISSED APPOINTMENTS, AND SAME DAY RESCHEDULED

Broken appointments represent a cost to us, to you, and to other patients who should have been seen in the time set aside for you. Cancellations and reschedules require a 24-hour notice. We reserve the right to charge a $30.00 fee for missed, same day cancelled or same day rescheduled appointments. We also have a $150.00 charge for missed surgical appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

COSMETIC APPOINTMENTS

All cosmetic appointments require a $50.00 deposit payable when making the appointment. The deposit will be applied at the time of treatment.
If you should miss that appointment, cancel or reschedule without 24 hours notice you forfeit the deposit.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

INSURANCE BENEFITS: We encourage our patients to discuss fees with us prior to any major medical or surgical procedure. We will bill your insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. You should contact your insurance company if you are not aware of what your copayment is. If we have not received payment from your insurance company within 90 days of the date of service you will be expected to pay the balance in full and collect from your insurance company. **You are responsible for all charges**. Should you fail to pay for services rendered, your account may be turned over to a collection agency or attorney for collection. Once your account is turned over to a collection agency or attorney, you shall be responsible for the full balance due plus an additional 30% of the current balance due to cover collection costs and/or attorney fees.

NO INSURANCE BENEFITS: For patients with no insurance or who receive cosmetic procedures, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangements are made in advance for a payment plan. RELEASE OF INFORMATION: I hereby authorize SAMI ABBASI, D.O., his associates or assistants to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment. I hereby authorize my insurance benefits to be paid directly to SAMI ABBASI D.O.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF THE SERVICE: Payment is required at the time services are rendered unless other arrangements have been made in advance with a member of our office staff. This includes applicable coinsurance and copayments for participating insurance companies. Our practice accepts cash, personal checks, VISA, Mastercard, AMEX, and Discover. There will be a charge of $30.00 for any returned checks. Patients with an outstanding balance of 90 days overdue must make arrangements for payment prior to scheduling appointments.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e. **BLUE CARE NETWORK**), you are responsible for obtaining your referral from your primary care physician and presenting it to our office at the time of the service.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

_____ _____
Signature of Patient or Other Legally Authorized Person Date

_____ _____
Print Patient Name if different than above Date