SINA J. SABET
MD, PC

New Patient Registration

Name: _____ Date of Birth: _____

1. Which physician referred you to Dr. Sina Sabet?_____

2. What condition are you being referred for? _____

3. When did your symptoms begin? _____

4. Have you had any imaging related to this problem? YES / NO

What type of imaging? _____

*Where was it done?*_____

5. Please list any other physicians you have seen for this, *including your Primary Care Physician*:

_____

_____

PLEASE BRING ALL MEDICAL RECORDS TO YOUR APPOINTMENT!

For example: related physician's notes, imaging reports and disks, etc.

Appointments can take at least two to three hours due to dilation and testing. Please allot the appropriate amount of time for your appointment!

5130 Duke St, Suite 9 ♦ Alexandria, VA 22304
P: (703) 370-9411 ♦ F: (571)-431-6778
www.sinasabetmd.com

SINA J. SABET MD, PC

CONDITIONS OF REGISTRATION

THE PRACTICE
Sina J. Sabet, M.D., and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice."

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory, and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION
In accordance with Virginia law, any patient whose bodily fluids a healthcare worker has been exposed to will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS
I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency). I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, the Health Care Financing Administration or The Centers for Medicare and Medicaid Services (CMS), needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Fees for copies of medical records are subject to change and will be in accordance with applicable state and federal laws. Please contact our office for the most current rates. I further agree to pay a $60.00 form fee for each form I require to be completed by The Practice.

REFERRALS AND AUTHORIZATIONS
If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not The Practice's to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my children, step-children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through, conformation or confirmation. I agree to pay a **$25.00 no show fee for non-surgical appointments and a $50.00 no show fee for surgical procedures** that are not canceled at least 24 hours in advance. I also agree to pay a **$25.00 no show fee for non-surgical appointments and a $50.00 no show fee for surgical procedures if I arrive more than 15 minutes late**. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize The Practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION
I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

_____	_____	_____/_____/_____
PRINT PATIENT NAME	**PATIENT SIGNATURE (or authorized to sign)**	DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY (HIPAA).

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a physical exam.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling/filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries: Sina J. Sabet, M.D., Attn: Privacy Officer, 5130 Duke St. Ste 9, Alexandria, VA 22304, 703-370-9411

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Service Office of Civil Rights, 200 Independence Ave, S.W., Washington, D.C. 20201, 202-619-0257, Toll Free: 877-696-6775

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

I have received and/or reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may at any time request, in writing from the Privacy Office, a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my protected health information is used or discussed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____	_____	_____/_____/_____
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THIS FORM IS DESIGNED TO COMPLY WITH HIPAA REQUIREMENTS
"NOTICE OF PRIVACY PRACTICES"

Date: _____/_____/_____

I, _____ give Dr. Sina J. Sabet, M.D. and/or their staff permission to
Print Name

release any medical information to or schedule appointments for me by the following person(s).

_____	_____	_____
First and Last Name	Phone Number	Relationship to the Patient
_____	_____	_____
First and Last Name	Phone Number	Relationship to the Patient
_____	_____	_____
First and Last Name	Phone Number	Relationship to the Patient

_____	_____	_____/_____/_____
PRINT PATIENT NAME	**PATIENT SIGNATURE (or authorized to sign)**	DATE

PATIENT'S RESPONSIBILITY

It is the patient's and/or patient's guardian(s)' responsibility to know their insurance policy. Patients and/or patient guardians should be aware of their benefit coverage, including which physicians, laboratories, and facilities are contracted with their insurance plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and copays. If you are not familiar with your plan coverage, we recommend that you contact your insurance carrier directly. I hereby consent to the scanning and storage of my identification card and insurance card in my secure electronic medical record for purposes of verification, billing, and treatment at this practice. I understand that this information will be maintained in accordance with all applicable privacy and security regulations, including but not limited to HIPAA.

_____	_____	_____/_____/_____
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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Dilation takes time after inserting drops to take effect. This means that a full dilated examination will take at least 90 minutes. If your time is limited and less than the required time, please let us know and we can focus the exam on the main reason you are having and perhaps reschedule the dilation at your convenience.

In patients previously diagnosed with angle-closure glaucoma, an adverse reaction may be triggered by the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby **(AUTHORIZE / NOT AUTHORIZE)** **Dr. Sina J. Sabet** and employees as may be designated by him to administer dilating eye drops. **The eye drops are necessary to diagnose my condition**.

DILATION:

1. **Do you authorize to receive drops? YES / NO**
    a. **IF NO:** Please understand that the doctor may not be able to detect all medical conditions affecting the eyes.
    b. Would you like to reschedule the dilation at a later time? **YES / NO**
2. **Have you had dilating drops before? YES / NO**
3. **Bad reaction? YES / NO** _____
4. **Allergies to the drops? YES / NO** _____
5. **On heart or blood pressure medication? YES / NO** _____
6. **Are you pregnant or breastfeeding? YES / NO** _____
7. **Have you been told you have narrow angle glaucoma in the past? YES / NO**

EYEGLASSES EXAM:
If you are here for an eyeglasses exam, please note that **your insurance may not cover this fee**. The patient will then be responsible for this **additional fee of $40.00**.

_____ _____ _____/_____/_____
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The information listed here is accurate as of the date of signing. Any updates will be told to the office staff.

PATIENT INFORMATION

Date:_____ Gender: ☐ Female / ☐ Male

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

Last Name: _____ M.I.:_____

First Name: _____

Date of Birth: _____/_____/_____

Address: _____

City: _____ State: ____ Zip: _____

RESPONSIBLE PARTY INSURANCE INFORMATION

Primary Insurance Company:_____

Member ID:_____ Group Number:_____

SSN#:_____ Date of Birth:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Secondary Insurance Company:_____

Member ID:_____ Group Number:_____

SSN#:_____ Date of Birth:_____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____ext.____

The best way to contact me is:

☐ Home Phone ☐ Work Phone ☐ Cell Phone

Would you like to receive text reminders? ☐Yes ☐No

PHARMACY PREFERENCE

Primary Pharmacy:_____

Address:_____

City:_____ State:_____

Zip:_____ Phone Number: (_____)_____

Email Address: _____

Would you like to sign up for the patient portal?

In patient portal you can see test results, future appointments, office notes and pay bills or copay

☐ Yes ☐ No

Social Security Number (Optional):_____

Marital Status: ☐Student ☐Single ☐Married ☐Widowed ☐Divorced ☐Engaged

LANGUAGE / RACE / ETHNICITY

Primary Language: ☐English ☐Spanish ☐Farsi ☐Arabic ☐Chinese ☐French ☐Russian ☐ASL ☐Other:_____

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White ☐Other:_____

Primary Care Physician:_____

Phone Number: (_____)_____

Fax Number: (_____)_____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Emergency Contact Information

First Name:_____

Last Name:_____

Relationship:_____

Phone Number: (_____)_____

Do you live alone? ☐Yes ☐No

Planning pregnancy? ☐Yes ☐No

Who do we thank for referring you?

_____

_____ _____ _____/_____/_____

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PATIENT HEALTH HISTORY FORM

Please answer the following questions to the best of your ability.

1. Medical Conditions

☐Arthritis
☐Asthma
☐Cataracts
☐Diabetes
☐Dizziness/Fainting
☐Glaucoma
☐Heart Problems
☐High Cholesterol
☐High Blood Pressure
☐HIV/AIDS
☐Hyperthyroidism
☐Liver Disease
☐Lung Disease
☐Lupus
☐Lyme Disease
☐Migraines
☐Multiple Sclerosis
☐Pacemaker/Defibrillator
☐Parkinson's Disease
☐Seizures
☐Sickle Cell Disease
☐Stroke
☐STD
☐Ulcers
☐Thyroid Disease
☐TIA
☐Valvular Problems

2. Medications and Doses

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

3. Allergies/Medication Allergies: _____
4. Surgeries: _____
5. Hospitalizations: _____

6. Smoking Status:

☐Vape user
☐Current, some days
☐Light tobacco smoker
☐Never smoked
☐Current smoker, everyday
☐Heavy tobacco smoker
☐Former smoker

If yes, packs per day:_____ How many years:_____

7. Do you drink alcohol?

YES / NO

_____(#) of drinks per
_____(Day, Week, Month, Year) *circle one*

8. Caffeine use?

YES / NO

If yes, servings per day:
1 2 3 4 5+
or Occasional Use

9. Family History:

Please list any family medical history, especially diabetes, high blood or heart pressure, heart disease, type(s) of cancer, etc.

☐Mother ☐Father ☐Sibling _____
☐Mother ☐Father ☐Sibling _____
☐Mother ☐Father ☐Sibling _____

10. Review of Systems: Please circle all that apply to you. "Y" for yes and "N" for no.

Eye:
Y/N Eyelid drooping
Y/N Redness
Y/N Blurred vision
Y/N Double vision

Hematology:
Y/N Bleeding
Y/N Easy bruising
Y/N Anemia

Musculoskeletal:
Y/N Neck pain
Y/N Back pain
Y/N Joint pain

General:
Y/N Generally well
Y/N Fever
Y/N Chills
Y/N Tired
Y/N Weight gain
Y/N Weight loss

Rheumatology:
Y/N Scalp tenderness
Y/N Pain w/ chewing

Pulmonary:
Y/N Cough
Y/N Shortness of breath

Gastrointestinal:
Y/N Nausea
Y/N Vomiting
Y/N Stomach pain
Y/N Blood in stool
Y/N Diarrhea
Y/N Constipation

Genitourinary:
Y/N Bladder control problems
Y/N Pain during urination
Y/N Blood in urine

Endocrine:
Y/N Temperature intolerance
Y/N Menstrual problems

ENT:
Y/N Hearing loss
Y/N Ringing in ears
Y/N Nose bleeds

Dermatology:
Y/N Rashes
Y/N Birthmarks
Y/N Moles

Cardiovascular:
Y/N Heart murmur
Y/N Chest pain
Y/N Irregular heart beats
Y/N Poor circulation

Psychological:
Y/N Anxiety
Y/N Depression
Y/N Nervousness
Y/N Hallucinations

Neurologic:
Y/N Balance problems
Y/N Confusion
Y/N Memory lapses/loss
Y/N Dizziness
Y/N Headache
Y/N Involuntary movement during sleep
Y/N Weakness
Y/N Speech difficulties
Y/N Tingling
Y/N Tremors
Y/N Difficulty walking
Y/N Involuntary movement

_____ PRINT PATIENT NAME

_____ **PATIENT SIGNATURE (or authorized to sign)**

_____/_____/_____ DATE

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