TELEMEDICINE PATIENT REGISTRATION, HIPAA ACKNOWLEDGMENT, AND BILLING INFORMATION

VISIT DATE: ______________________________

PATIENT NAME:

____

ADDRESS:

____

____

TELEPHONE NUMBERS (CIRCLE PREFERRED):

HOME:

WORK:

CELL:

BEST TIME TO REACH YOU BY PHONE:

RACIAL/ETHNIC ORIGIN:

- ☐ AFRICAN
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN/PACIFIC ISLANDER
- ☐ EUROPEAN
- ☐ HISPANIC
- ☐ MIDDLE EASTERN
- ☐ OTHER:____________________________________

BIRTHDATE (MO/DAY/YR):_________________

SEX: MALE FEMALE TRANS/M TRANS/F

AGE: ____

SS#: ____

DRIVER LIC #:____________________________________

PREFERRED LANGUAGE:

____

MAY WE CONTACT YOU BY EMAIL? YES NO

EMAIL ADDRESS: :_______________________________

MAY WE LEAVE VOICEMAIL MESSAGES AT YOUR HOME/WORK/CELL #?

YES NO

MARITAL STATUS (CIRCLE):

SINGLE
MARRIED
SEPARATED
DIVORCED
WIDOWED
PARTNERED FOR ___ YEARS

SPOUSE'S INFORMATION (OR PARENT/GUARDIAN INFORMATION FOR MINORS):

NAME:
ADDRESS:
EMPLOYER:

DATE OF BIRTH:
PHONE NUMBERS: (H,W,C):
SS#:

MAY WE SHARE PROTECTED HEALTH INFORMATION (PHI) WITH YOUR SPOUSE? YES NO

IN CASE OF EMERGENCY, CONTACT (NAME):____

HOME PHONE:___________________________________ CELL PHONE:____
WORK PHONE:____________________________________ RELATIONSHIP TO YOU:______________________________

WHOM MAY WE THANK FOR REFERRING YOU?____

HIPAA ACKNOWLEDGMENT: I have received a copy of this medical practice's Notice of Privacy Practices through their office website: www.mikailmd.com

Signature: ____________________________________Date: _________________________

INSURANCE AND BILLING INFORMATION

VISIT DATE:___________**PATIENT NAME:**_____________________________**DATE OF BIRTH:**____________

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

NAME:
RELATIONSHIP TO PATIENT:
DATE OF BIRTH:

INSURANCE COMPANY NAME:
INSURANCE COMPANY ADDRESS:
INSURANCE COMPANY PHONE NUMBER:
GROUP #/POLICY #:

SECONDARY INSURANCE INFORMATION:

IS PATIENT COVERED BY ADDITIONAL INSURANCE? (CIRCLE ONE) YES NO
SUBSCRIBER'S NAME:
SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S SS#
RELATIONSHIP TO PATIENT:
INSURANCE COMPANY NAME:
INSURANCE COMPANY ADDRESS:
GROUP #/POLICY#:

INSURANCE ASSIGNMENT AND RELEASE: I certify that I (and/or my dependents) have insurance coverage with the insurance company named above, and I will submit a Member Claim Form to my insurance company or Dr. Mikail's office will submit one on my behalf for medical services received from Dr. Claudia Mikail. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I have not paid my insurance premium on time my insurance plan might not pay for my medical care, and I will be responsible for payment for the services provided. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and/or determining insurance benefits and/or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below, whichever is later.

PLEASE SIGN AND DATE BELOW:

____ ________________
Signature of Beneficiary, Guardian, or Personal Representative Date

____ ________________
Please print name of Beneficiary, Guardian, or Personal Representative Date