TELEMEDICINE PATIENT REGISTRATION, HIPAA ACKNOWLEDGMENT, AND BILLING INFORMATION

VISIT DATE: _____ **BIRTHDATE (MO/DAY/YR):**_____

PATIENT NAME: **SEX**: MALE FEMALE TRANS/M TRANS/F

_____ **AGE**: _____

ADDRESS: **SS#:** _____

_____ **DRIVER LIC #**:_____

_____ **PREFERRED LANGUAGE**:

TELEPHONE NUMBERS (CIRCLE PREFERRED): _____

HOME: **MAY WE EMAIL YOU HEALTH-RELATED MESSAGES?** YES NO

WORK: **EMAIL ADDRESS:** :_____

CELL: **MAY WE LEAVE VOICEMAIL MESSAGES AT YOUR HOME/WORK/CELL #?** YES NO

BEST TIME TO REACH YOU BY PHONE:

RACIAL/ETHNIC ORIGIN:

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

MARITAL STATUS (CIRCLE):

SINGLE
MARRIED
SEPARATED
DIVORCED
WIDOWED
PARTNERED FOR ___ YEARS

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

NAME: DATE OF BIRTH:
ADDRESS: PHONE NUMBERS: (H,W,C):
EMPLOYER: 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 (IF NONE, WRITE "NONE"):
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 (if applicable). I understand that I am financially responsible for all charges by Dr. Mikail's office whether or not paid by insurance. I understand that if I have not paid my insurance premium on time, have not fulfilled my deductible, or the services I receive are not covered by my health insurance plan, my insurer 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 by Dr. Mikail's office. 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. I will verify potential charges for any lab tests, imaging, referrals, or other procedures related to my care directly with my insurer and the service provider before proceeding with them.

PLEASE SIGN AND DATE BELOW:

_____ _____
Signature of Beneficiary, Guardian, or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian, or Personal Representative Date