PATIENT INFORMATION FORMS PLEASE RETURN PROMPTLY ***PLEASE WRITE LEGIBALLY*** **TODAY'S DATE _____**

FULL NAME*_____SS#_____OR COPY OF DL

DATE OF BIRTH_____GENDER_____MARITAL STATUS_____EMPLOYER_____

YOUR ADDRESS_____CITY_____STATE_____ZIP_____

EMAIL*_____REFERRED BY_____

PHONE HOME _____ WORK_____ CELL_____

EMAIL STATEMENTS/BILLS ? YES / NO** ** **PAY ONLINE WITH INVITE TO PATIENT PORTAL ? YES / NO**

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD AND PRESCRIPTION CARD NOW

INSURANCE WITH _____ POLICY ID#_____

IF DIFFERENT, POLICY HOLDER NAME_____RELATIONSHIP TO PATIENT_____

THEIR DATE OF BIRTH_____THEIR EMPLOYER_____ *SAME NAME ON POLICY ID# YES / NO

IF DIFFERENT, BEHAVIORAL / MENTAL HEALTH COVERAGE ADMINSITERED BY _____

CO-PAY FOR BEHAVIORAL HEALTH / SPECIALIST _____ DEDUCTIBLE _____PRESRIPTION CARD ID____

PARENT/LEGAL GUARDIAN WHO SIGNS BELOW ** ASSIGNMENT OF FINANCIAL RESPONSIBILITY FOR UNDER AGE 18

NAME_____ *EMAIL FOR BILLING _____

RELATIONSHIP TO PATIENT_____SS#_____ DATE OF BIRTH_____

STREET_____CITY_____STATE_____ZIP_____

PHONE_____

TREATMENT AGREEMENT AND CONSENT TO BE TREATED BY MIRANDA MOHABIR, MD – PATIENT SIGNATURE REQUIRED :

I agree (or the parent/legal guardian agrees) to pay a no-show fee or late cancelation fee when I fail to give 24 hours' notice and/or not show up for my appointment. The charge will be in accordance with the amount of time reserved for me. WE DO NOT OFFER COURTESEY APPOINTMENT REMINDERS OR TEXTS. I consent to treatment and to be seen by Miranda Mohabir, MD with this treatment agreement.

SIGNATURE OF PATIENT_____DATE_____

RELEASE OF PAYMENT DIRECTLY TO PROVIDER AND I WILL PAY FOR SERVICES IN A TIMELY MANNER: I authorize the release of information necessary to process a claim to my insurance. I authorize payment of covered services directly to the provider. Actions taken on a claim can be explained by me calling my insurance company or looking up the claim on my insurance website. I accept financial **responsibility to pay the provider for billed services within 30 days of the statement date** for charges not covered by insurance, deductibles, copays, coinsurances, insurance retractions, fees for filling out forms and for no show fees and late cancel fees (which are only excusable by the provider).

SIGNATURE OF PATIENT_____DATE_____

SIGNATURE OF PARENT/LEGAL GUARDIAN_____DATE_____ ***GO TO PAGE 2*

++

FOR OFFICE USE ONLY DIAGNOSIS CODE 1: _____ 2: _____3: _____

TO GIVE YOUR INFORMATION TO OTHERS, YOU MUST SAY TO WHO AND SIGN BELOW

RELEASE OF PATIENT INFORMATION And Acknowledgment of Receipt of Notice of Privacy Practices**.**

The confidentiality of patient records will be maintained according to the Privacy Act of 1974 and Health Insurance Privacy and Accountability Act (HIPAA). **Any release of patient information** not covered under "Other Uses" provision of the Privacy Act and/or HIPAA **must be authorized by the patient**, the patient's legal guardian or by court order. Patients are informed of their HIPPA rights at registration. A copy of the Privacy Act/HIPAA is available on request.

Please read carefully.

The Patient authorizes the Release of patient information to: Parent, legal guardian, person paying bill, email addresses, other Doctors to receive information. And Dr. Mohabir can release my patient information for referrals.

_____

_____

Patient's Printed Name _____ **Patient's Signature**_____

****Release to FINANCIAL RESPONSIBILITY PARENT/LEGAL GUARDIAN on page 1 *is required.* *EMAIL ADDRESS PROVIDED MAY BE FOR BILLING AND PROTECTED PATIENT INFORMATION AND MAY BE SENT UN-ENCRYPTED WITH THIS SIGNED RELEASE**

++

_____***FOR OFFICE USE***_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: _____Individual Refused to sign _____Communications barriers prohibited obtaining the acknowledgement _____Other: _____

++

FOR INSURANCE AND PRESCRIPTION EXPLANATION OF BENEFITS YOU CAN LOOK UP ONLINE AT YOUR INSURANCE WEBSITE OR CALL THE NUMBER ON THE BACK OF YOUR ID CARD. MAKE A COPY OF THESE FORMS FOR YOUR RECORDS.

RETURN ALL SIGNED DOCUMENTS TO MAILING ADDRESS OR EMAIL BELOW

MIRANDA MOHABIR, MD PC 8295 CAZENOVIA ROAD MANLIUS, NY 13104
PHONE = 315-682-0213 FAX = 315-682-4411
EMAIL FOR BILLING/RECORDS = MMMDBILLING@YAHOO.COM

TELEMED INSURANCE BENEFITS CAN BE FOUND ONLINE
AT YOUR INSURANCE WEBSITE OR CALL THE NUMBER ON THE BACK OF YOUR ID CARD.

Informed Consent for Telemedicine Services

PATIENT NAME = ____ DATE OF BIRTH = _________________________

LOCATION OF PATIENT = ____

PHYSICIAN NAME = Miranda Mohabir, MD LOCATION = Office DATE CONSENT DISCUSSED = __________________

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Miranda Mohabir, MD P.C. providing health care services to me via telemedicine.
I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I can request an EXPLANATION OF BENEFITS – EOB - from my insurance company to explain the actions taken on the claim.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Miranda Mohabir, MD P.C. at 315-682-0213 / 8295 Cazenovia Road, Manlius, NY 13104.
As long as this consent is in force (has not been revoked) Miranda Mohabir, MD P.C. may provide health care services to me via telemedicine without the need for me to sign another consent form.

SIGNATURE OF PATIENT____ **DATE**_____________________________

PERSON AUTHORIZED TO SIGN FOR PATIENT____

RELATIONSHIP TO PATIENT____ DATE_____________________________

I have been offered a copy of this consent form (**PATIENT'S INITIALS**)____

~~~~~~

CREDIT CARD ON FILE FORM - WE DO NOT DO AUTOMATIC PAYMENTS

Credit Card on File Authorization is to allow processing of credit card information <u>when you give full credit card information in person, by text, or sent in writing to the medical practice for payment on your account.</u>

We are discontinuing CREDIT CARD PAYMENTS OVER THE PHONE.

Information to be completed by cardholder: The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.
Medical Practice: MIRANDA MOHABIR, MDPC 8295 CAZENOVIA ROAD MANLIUS, NY 13104

PATIENT'S NAME __________________________ **NAME THAT APPEARS ON CREDIT CARD**_______________________

Type of Credit Card: MasterCard / Visa / Discover / Amex **CREDIT CARD BILLING ZIP CODE**_____________

Last 4 Digits of Card: ☐ ☐ ☐ ☐ **Expiration Date**:___________________

I authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice at the address listed above.

____ _______________________________

Cardholder's Signature Date
~~~~~~