Homan Hajbandeh, M.D., P.L.L.C.
George Roso, M.D., P.L.L.C.

Patient Registration Form

Today's Date: _____

PATIENT NAME: _____ ☐ Male ☐ Female

HOME PHONE: _____ CELL PHONE: _____ May we text you? ☐ YES ☐ NO

ADDRESS: _____ APT#: _____ CITY: _____

EMAIL: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SSN: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

LANGUAGE PREFERENCE: ☐ English ☐ Spanish ☐ Other: _____

RACE:
☐ American Indian or Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American
☐ Hispanic or Latino
☐ Asian
☐ White
☐ Other: _____
☐ Decline to report

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION: ☐ No insurance

Insurance Company _____ Insurance Address _____ Insurance Phone Number _____

Subscriber ID #: _____ Group #: _____ Copay: $ _____

Policy Holder's Name: _____ ☐ Patient is the policy holder (**Skip to next section.)**

Relationship to patient: ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder SSN: _____ Policy Holder birthdate: _____

Policy Holder Phone: ☐ Same as above OR: Home: _____ Cell: _____

Policy Holder Address: ☐ Same as above OR: Email: _____

Address _____ Apt # _____ City _____ State _____ Zip code _____

SECONDARY INSURANCE INFORMATION: ☐ No secondary insurance

Insurance Company _____ Insurance Address _____ Insurance Phone Number _____

Suscriber ID #: _____ Group #: _____

Policy Holder's Name: _____

☐ Patient is the policy holder **(Skip to next section.)** ☐ Same as Primary Ins. **(Skip to next section.)**

Relationship to patient: ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder SSN: _____ Policy Holder birthdate: _____

Policy Holder Phone: ☐ Same as above OR: Home: _____ Cell: _____

Policy Holder Address: ☐ Same as above OR: Email: _____

Address _____ Apt # _____ City _____ State _____ Zip code _____

LOCAL PHARMACY:

Name _____ Address or Cross Streets _____ Phone _____ Fax _____

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST FOR COPYING

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Health History Information

Patient Name: _____ Date of birth: _____

Do you have an Advance Directive/Living Will/Health Care Power of Attorney? ☐ Yes ☐ No

INSTRUCTIONS: Put an (X) in the appropriate box for each question. DO NOT SKIP ANY.

HAVE YOU EVER HAD:

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Depression	☐	☐	Liver disease
☐	☐	Anxiety	☐	☐	Diabetes mellitus	☐	☐	Migraine/frequent headaches
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Osteopenia
☐	☐	Asthma	☐	☐	Hayfever/seasonal allergy	☐	☐	Osteoporosis
☐	☐	Bleeding disorder	☐	☐	Heart disease	☐	☐	Sleep Apnea
☐	☐	Cancer			Type:	☐	☐	Thyroid disease
		Type:	☐	☐	High blood pressure	☐	☐	Other:
☐	☐	Cataracts	☐	☐	High cholesterol/triglycerides	☐	☐	
☐	☐	COPD	☐	☐	Kidney disease (chronic)	☐	☐	

Please list any additional problems, concerns, or information about you that you would like the doctor to know about:

_____

CURRENT MEDICATIONS AND DOSAGE: (Include non-prescription drugs/supplements)

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES OR OTHER REACTIONS: _____

LIST ANY PAST SURGERIES AND APPROXIMATE DATES: _____

_____

IMMUNIZATIONS CURRENT? ☐ **Yes** ☐ **No** **DATE OF LAST TETANUS:** _____

THE FOLLOWING QUESTIONS REFER TO YOUR LIFESTYLE:

TOBACCO USE: ☐ **Current** ☐ **Past** ☐ **Never**
If so, please check the following: ☐ **Chew** ☐ **Smoke** **Packs daily?** _____

How long? _____ **If you quit, when did you quit?** _____

ALCOHOL USE: ☐ **Never** ☐ **Rarely** ☐ **Frequently** ☐ **Daily**

MARIJUANA USE: ☐ **Current** ☐ **Past** ☐ **Never**

OTHER RECREATIONAL DRUG USE: ☐ **Current** ☐ **Past** ☐ **Never**
If so, what drugs? _____

FAMILY HISTORY: Have any of your <u>blood relatives</u> ever had the following?

Please check:	Relationship to you?	Please check:	Relationship to you?
☐ **Asthma/COPD**	_____	☐ **High blood pressure**	_____
☐ **Cancer: (type?)** _____	_____	☐ **Stroke**	_____
☐ **Cancer: (type?)** _____	_____	☐ **Other:** _____	_____
☐ **Diabetes mellitus**	_____	☐ **Other:** _____	_____
☐ **Heart attack or heart disease**	_____	☐ **Other:** _____	_____

PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT

Patient Name _____ Date of birth _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone: ( ) _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ Cell Phone: ( ) _____ May we text you? ☐ YES ☐ NO

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ Other: _____

_____

I authorize George Roso, MD, PLLC and Homan Hajbandeh, MD, PLLC to discuss my protected health information with the following family members or others involved in my care:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: ( ) _____ Phone number: ( ) _____

☐ Please check mark if you **decline** to add anyone at this time.

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available on the website and in the office.

_____ _____

Patient/Guardian Signature Date

Homan Hajbandeh, M.D., P.L.L.C.
George Roso, M.D., P.L.L.C.

Office Policies

Patient Name: _____ Date of birth: _____

1. Our office requires all patients to provide proof of identity, generally a driver's license.
2. You are responsible to notify our office of any changes to your contact information.
3. You need to bring the following items to every appointment: current insurance card, payment method, and current medications, vitamins, and supplements including doses and instructions.
4. In the waiting room and in other places within our office, please be considerate of other patients and staff members by turning off or silencing your cell phone.
5. Appointments: If you arrive more than 15 minutes late to your scheduled appointment, we will make every attempt to see you. However, your appointment may need to be rescheduled and you may incur charges for a missed appointment. As a courtesy, we make reminder calls for upcoming office visits. If you do not receive a reminder call, you are still responsible to arrive at your appointment date and time. Reminder calls are not made for lab visits.
6. Prescriptions: All new prescription requests (including antibiotics and controlled substances) require an office visit with the provider. Medication refill requests require 48 hours' notice for processing. **Do not wait until you are out of your medication before calling for a refill!** For refills of existing prescriptions, please contact your pharmacy first, and they will notify our office that you are due for refills. You may need a follow-up appointment with your provider before refills will be given, depending on your health condition. **If you are overdue for your follow-up visit, refills may not be given.** Our office does not fax new mail-order prescriptions to your mail order pharmacy. We will give them directly to you to mail in. If you need a refill of a mail-order prescription, contact your mail order pharmacy first, and they will notify our office that you are due for refills. Patient prescription history may be verified using an external secure database.
7. Referrals: Some insurance companies require your primary care physician to obtain prior authorization before referring you to a specialist. If your plan requires this, we will request the authorization from your insurance company within three (3) business days and notify you when you can schedule your appointment with the specialist. Once you have scheduled the appointment, please notify our Referral Specialist at least 72 hours prior to your appointment date so that she has ample time to send any appropriate documentation to the specialist's office.
8. LAB: Our office is contracted with Sonora Quest Laboratories to offer convenient phlebotomy service to our patients. You are NOT required to use our in-office lab for your blood draws. Sonora Quest Laboratories follows their own process for patient verification, and will bill you separately for their services.
9. If results of laboratory or radiology tests are not given to you within 7 business days, please call our office.
10. Medical records: We will transfer your medical record directly to a new doctor or specialist free of charge. You are entitled to one copy of your medical record for personal use, which will be provided to you free of charge. Please allow 72 hours to complete the request. Repeat copies for personal use will be charged a $25 or $50 fee, depending on the size of the medical record.

IMPORTANT: Failure to abide by these Office Policies may result in you being discharged from our practice. If this is to occur, we will send you a notification via certified mail that you have 30 days to find alternate medical care. During that 30-day period, our physician will only be available to treat you on an emergency basis. (04/2016)

_____ _____

Patient/Guardian Signature Date

Homan Hajbandeh, M.D., P.L.L.C.
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Financial Policy and Waiver of Non-covered Services

Patient Name: _____ Date of birth: _____

1. INSURANCE: We accept assignment of insurance benefits at the time of service. Please provide our office with proof of EVERY insurance plan you are contracted with. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your coverage pertaining to deductibles, co-pays, contracted lab & radiology facilities, and if we are listed as a provider for your particular health plan. If you are not insured by a plan we are contracted with, or do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not provide your up-to-date insurance information at the time of service, you are responsible to pay the balance of the claim unpaid by your insurance.
2. COPAYS, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their copayments, deductibles, and past due balances at the time of service.
3. NON-COVERED SERVICES: Please be aware that some, and perhaps all, of the services you receive may not be covered by your insurance company and/or Medicare. It is your responsibility to know your coverage benefits. You have the right to refuse any tests, treatments, or services that are not covered by your insurance company. You will be responsible to pay for services rendered that are not covered by your insurance company.
4. CLAIMS: We will submit the claims for your visit to your insurance company and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company "should" pay your claim. If your insurance company has not paid your account in full within 90 days, the balance will automatically be billed to the patient unless previous arrangements have been made with our billing company.
5. NON-PAYMENT/COLLECTIONS: If your account becomes overdue, you will be sent a letter stating that you have thirty (30) days to pay your account in full or it may be turned over to our Collections Agency. The letter will also state that all non-emergency services from our office (including prescription refills) are being immediately suspended until your current balance has been paid. Partial payment will not be accepted unless otherwise negotiated. Once your balance has been paid in full, services from our office including prescription refills will resume immediately. If we are unable to contact you due to a change in your address or phone number that was not reported to our office, you are still responsible for all unpaid bills and fees according to the schedules in this Payment Policy.
6. OTHER FEES:
    a. We charge a $50 fee for appointments that are missed, cancelled, or rescheduled, unless our office is notified 24 hours in advance.
    b. If a check is returned due to insufficient funds, you will be charged an additional $25 service fee.
    c. If your account is turned over to our Collections Agency, you will be assessed an additional fee of 25% above the overdue principle balance to cover the processing charges.
    d. There is a charge for repeat requests for medical records for your personal use (please see Office Policies form).

IMPORTANT: Failure to abide by these Financial Policies may result in you being discharged from our practice. If this is to occur, we will send you a notification via certified mail that you have 30 days to find alternate medical care. During that 30-day period, our physician will only be available to treat you on an emergency basis. (12/2024)

I HAVE READ THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY MY HEALTH CARE PROVIDER. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY (MEDICARE AND/OR ANY OTHER INSURANCE COMPANY) FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO MY HEALTH CARE PROVIDER.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY THE ASSOCIATED FEES AND BALANCES AS DESCRIBED ABOVE.

_____ _____

Patient/Guardian Signature Date