Syed M. Ahmad, M.D.

Oculofacial and Reconstructive Surgery

Patient Information

Name _____ Date of Birth _____
last name first name mi.

Social Security # _____ Age _____ Male _____ Female _____

Address _____
Street Apt# City State Zip

Home Phone _____ Work Phone _____ Cell Phone_____
Ok to leave a message: Yes or No Yes or No Yes or No

Email Address: _____ May we contact you via email: Yes or No

Race _____ Ethnicity _____ Language_____

Marital Status (please circle): Single Married Separated Divorced Widowed

Occupation: _____ Employer: _____

Insurance Information

Primary Insurance: _____ Member ID: _____ Group#_____

Secondary: _____ Member ID: _____Group#_____

***If subscriber to insurance is other than "Self", please provide the following*:**

Name:_____ Relationship to Subscriber _____DOB of Insurance Subscriber:___/___/__

Emergency Information /Confidential Patient Contact Person

Please list a local relative or friend that we may contact in case of emergency. Based upon your written consent here-in, the person specifically listed below is the only person to whom information will be released other than you, the patient.

Name _____Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone_____

Primary Reason for Examination: _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Preferred Pharmacy _____ Phone/address_____

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Medications with Dosages

Preferred Pharmacy _____ Phone or address: _____

Drug Allergies

Past Surgical Procedures & Dates

Social History

Do you smoke? Yes No If previous smoker, when did you quit? _____

How many years? _____ How many packs a day? _____

Do you drink alcoholic beverages? Yes No Average number of drinks per day: 1 2-3 4+

Have you been HIV tested? Yes No HIV test results: Positive Negative

Are you pregnant or nursing? Yes No

Are you under the care of a doctor? Yes No

If yes, please explain: _____

I hereby request and consent to treatment for myself or my child at the office of Syed M. Ahmad, M.D.

_____

Signature Date

Syed M. Ahmad, M.D.

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Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Syed M. Ahmad, M.D. for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Receiving Specialized Services and/or Procedures

As a courtesy to me, Syed M. Ahmad, M.D. has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that Syed M. Ahmad, M.D. has acted in good faith in this effort and that the benefit information provided to Syed M. Ahmad, M.D. by my health insurance company may not be accurate.

I acknowledge that the benefit information obtained by Syed M. Ahmad, M.D. on my behalf was qualified by a representative of my health insurance company with the following statements:

1) This is an estimate of the benefits provided under the patient's insurance contract;

2) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service;

3) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time of service are rendered.

****Please be aware that refractive coverage is not a medical insurance benefit. If you would like to request an eyeglass prescription, this will be a $45 fee in addition to the exam charges. ****

Patient/Responsible Party Signature Date

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Financial Policy

Thank you for choosing Syed M. Ahmad, M.D. for your eye care needs. Our primary mission is to deliver the best and most comprehensive care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

You may choose from: Cash, Check, Visa, MasterCard, American Express, or Care Credit. Syed M. Ahmad, M.D. charges $35 for returned checks. Payment by check for all surgical procedures must be made a minimum 7 days before surgery.

It is customary to pay for professional services when rendered. As a courtesy, we will bill your insurance company on your behalf. Your insurance is a contract between you and your insurance carrier. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles, or non-covered services as determined by your insurance company. Any balance remaining after your health plan pays will be due upon receipt of a statement.

If you have not met your deductible, you will be responsible for 100% of your visit at the contracted rate.

If, however, Syed M. Ahmad, M.D. is not a participating provider in your insurance plan, you will responsible for filing your own claims and will be responsible for paying in full at the time of service.

In accordance with our contract with your insurance provider, we are responsible for collecting and you are responsible for paying for your exam.

Syed M. Ahmad, M.D. will verify your insurance eligibility prior to your appointment; however this is not a guarantee of payment by your insurance company.

If your insurance policy requires pre authorization from your primary care physician, it is your responsibility to obtain this prior to your appointment. If the claim for your services is denied for no pre-authorization, you will be responsible for your visit.

There is a $25 fee for any forms to be completed by Dr. Ahmad or staff (i.e., disability, workers comp, auto accident etc.).

The adult accompanying a minor and his/her parents (or guardian) are responsible for payment upon completion of the exam.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

_____

Patient Name (Please Print)

_____

Patient, Parent, or Guardian Signature Date

*If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Syed M. Ahmad, M.D. may use and disclose protected health information about me to carry out treatment, payment and healthcare operation. Please refer to Syed M. Ahmad, M.D. Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Syed M. Ahmad, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices bo forwarding a written request to Syed M. Ahmad, M.D., 3950 W. Plano Pwky Ste. A,Plano, Tx 75075.

With my consent, Syed M. Ahmad, M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among other.

With my consent, Syed M. Ahmad, M.D. may e-mail to my home or other designated location at times that assist the practice in caring out TPO, such as appointment reminder cards and patient statements. I have the right to request that Syed M. Ahmad, M.D. restrict how it uses or discloses my PHI to carrying out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Syed M. Ahmad, M.D. use and disclosure of my PHI to carry out TPO. I am acknowledging that I have received Syed M. Ahmad, M.D. Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Syed M. Ahmad, M.D. may decline to provide treatment to me.

_____

Patient Name (Please Print)

_____

Patient, Parent, or Guardian Signature Date

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
15823 Revision of upper eyelid	May be deemed cosmetic	
67900 Repair brow defect	May be deemed cosmetic	
67904 Repair eyelid defect	May be deemed cosmetic	
67917 Repair eyelid defect	May be deemed cosmetic	
92285 Eye photography	May be deemed cosmetic	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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