Patient Name: _____
Last First Middle

Date of Birth: _____
(MM/DD/YYYY)

Social Security Number:_____-_____-_____

Address: _____

_____
City State Zip Code

Home Phone Number: _____
Cell Phone Number: _____
Work Phone Number: _____
Email address: _____

Can we call your home numbers? Yes No

Can we call your cell number? Yes No

Can we call your work number? Yes No

Can we leave a message with your lab results? Yes No
If yes, at which number? _____

Pharmacy Information

Name of Pharmacy: _____

Address of Pharmacy: _____
_____
City State Zip Code

Phone number of Pharmacy: _____
Fax number of Pharmacy: _____

Emergency Contact

Name:_____ Relation: _____

Address: _____ _____

_____
City State Zip Code
Phone #: _____

Who referred you or how did you hear about us? _____

Who is your primary care doctor? _____

Address: _____

Phone#: _____ Fax#: _____

Notice to Patients

I _____ authorize payment to be made directly to Shady Grove Minimally Invasive Surgery and Gynecology Care of all insurance or health care plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance or other agencies, and for any co-pays, deductibles and/or coinsurance. In the event my insurance requires a referral, I acknowledge it is my responsibility to present a valid referral at the time services are rendered. In the event a referral is not presented and my insurance denies payment, I acknowledge the responsibility of the balance due to be my responsibility. If my account is placed with a third party in order to effect collection, I agree to be responsible for all costs of collection which may include but are not limited to: attorney fees, court costs, third party billing, credit reporting fees, collection agency fees, etc. It is required that all patients present their insurance CARDS AND PHOTO ID at every visit, to ensure HIPPA regulations are being followed. It is the patient's responsibility to know her insurance coverage/benefits and is responsible for all services not covered by her insurance.

Patients Name: _____

Signature: _____

Witness: _____

Date: _____

2403 Research Blvd, suite 200

Rockville, MD 20850

Office: 240-912-4546

Fax: 240-912-4471

INSURANCE INFORMATION

POLICYHOLDER INFORMATION

Policyholder Name: _____
First Name Middle Name Last Name

Date of Birth: ___/___/_____ relationship to patient:_____

Primary Insurance:

Insurance Carrier: _____ Effective Date:_____

Address _____ City_____ State/Zip code_____

Policy number: _____ Group Number: _____

Secondary Insurance:

Policyholder Name: _____

Date of Birth: ___/___/_____ relationship to patient:_____

Insurance Carrier: _____ Effective Date:_____

Address _____ City_____ State/Zip code_____

Policy number: _____ Group Number: _____

NOTICE TO PATIENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM.

Our handout "We Care about Your Privacy" provides information about how Shady Grove Minimally Invasive Surgery & Gynecology Care/Shabnam Dadgar, M.D. may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPPA).

Our "We Care about Your Privacy" notice states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date.

You have the right to request restrictions on the use and disclosure of your medical records / information; however the provider is not required to agree to restrictions not guaranteed by law. You will be informed if Shady Grove Minimally Invasive Surgery & Gynecology Care does not agree to your requested restrictions.

By signing below, you acknowledge receipt of our "We Care about Your Privacy".

_____ _____

Patient's Signature Date

_____ _____

Print Patient's Full Name Date

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except, where we have already made disclosures in trust on your prior consent.

I request that payment of authorized medical insurance carrier benefits be made on my behalf to Shady Grove Minimally Invasive Surgery & Gynecology Care for any services furnished to me by my physician. I authorize any holder of medical information about me to release to Shady Grove Minimally Invasive Surgery & Gynecology Care and his agent and/or any other insurance carriers for which I have coverage, any information deeded to determine these benefits or the benefits related services. I agree to provide all reference and treatment plan (s) as required by my insurance carrier (s). All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements.

_____ _____

Patient's Signature Date

_____ _____ _

Print Patient's Full Name Date

PERSONAL REPRESENTATIVE, FAMILY OR OTHER AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED.

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

_____ _____ _____

Name of Authorized Person or Entity Relationship Phone #

_____ _____ _____ _____

Name of Authorized Person or Entity Relationship Phone #

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL.

Shady Grove Minimally Invasive Surgery & Gynecology Care and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devises provide by our patients. Due to the federal mandated HIPPA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare information that we may possibly disclose on your home, work or cell phone would include, but not limited to: prescription/pharmacy information, test/lab results, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____(Initial) Yes, I agree to allow Shady Grove Minimally Invasive Surgery & Gynecology Care and his healthcare staff to leave messages that include Protected Healthcare Information on the following: please initial next to the applicable communication devices: _____home number, _____work number, _____cell number.

_____(Initial) No, I do not agree to allow Shady Grove Minimally Invasive Surgery & Gynecology Care and his healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone numbers.

_____ _____

Patient's Signature Date

**********UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGMENT**********

I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ___/___/_____, but was unable for the following reasons:

Print Patient Name: _____ Account #: _____

I, _____ attest that the above statements are true and correct.

Employee Signature: _____ Date: _____

If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Shabnam Dadgar, M.D. 240-912-4546.

Authorization for Release of Medical Information

Please print:

Patient name:_____ DOB:____/____/_____

Address:_____

Phone#:_____ Alternate Phone:_____

Shady Grove Minimally Surgery and Gynecology Care has permission to release information contained in the medical Records of the above named patient.

Information requested (please be specific and enter date of service known.)
Restrictions and/or exclusions (if any):
Shady Grove Minimally surgery and Gynecology Care has permission to give information requested to the following party: Name:_____ Relationship to patient:_____ Address:_____ Phone #:_____ Fax:_____

Signature of patient:_____Date:____/_____/_____

OR

Signature of Representative:_____Date:___/____/_____

Minimally Invasive Surgery and Gynecology Care
2403 Research Blvd, Suite 200
Rockville, MD 20850
Phone: 240-912-4546
Fax: 240-912-7741

At the time of your appointment, you must pay your Co-Pay and any outstanding Deductible before being seen by the doctor.

Sincerely,

Shabnam Dadgar, MD, FACOG, FMIGS

Patient _____ Date _____