Intercare Clinic
Humaira Khan, MD
4850 W. Oakland Park Blvd, Suite 115, Lauderdale Lakes, FL 33313
Tel (954) 486-8663 Fax (954) 486-8979

PLEASE READ AND COMPLETE EVERY SECTION BELOW IN ITS ENTIRETY.
This information is required by your insurance company. All pages must be signed and dated.

FINANCIAL POLICY & PROCEDURE

I authorize payment of insurance benefits to be made directly to Humaira Khan, MD for services rendered. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees, and I authorize this healthcare provider to release information necessary to secure payment of benefits. I agree that a photocopy of this authorization is as valid as the original.

In accordance with Florida State Law, I authorize Humaira Khan, MD to file a formal written complaint on my behalf to my insurance company, and to the Florida State Insurance Commissioner, if payment for services is not received within thirty (30) days from the date of filing.

Responsibility for Payment

The patient, their parent or guardian, or the person/agency requesting treatment is fully responsible for all charges incurred. Every effort will be made to verify insurance eligibility and benefit coverage; however, insurance seldom covers the entire fee, and the patient is responsible for their co-pay at each visit.

PATIENT / RESPONSIBLE PARTY SIGNATURE

PRINT NAME

DATE

REFERRALS

48-hour notice required

Referral requests require at least 48 hours notice to process — no exceptions.

EMERGENCIES

Call 911

In an emergency, call 911 or go to the nearest ER. Only urgent messages are forwarded to Dr. Khan after hours. Contact your pharmacy directly for refills.

INITIAL THIS PAGE

DATE

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Patient Information Record

PATIENT DEMOGRAPHICS

PATIENT LEGAL NAME

DATE OF BIRTH

EMAIL ADDRESS

CELL PHONE

HOME PHONE

STREET ADDRESS

CITY

STATE

ZIP

SOCIAL SECURITY #

EMERGENCY CONTACT NAME & PHONE

SEX

☐ Male ☐ Female ☐ Other

DEMOGRAPHIC CATEGORIES (FOR INSURANCE REPORTING — SELECT ONE PER ROW)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Race: ☐ Caucasian ☐ Asian ☐ Native Indian ☐ Alaskan ☐ African Amer. ☐ Hawaiian ☐ Declined

Religion: ☐ Buddhist ☐ Catholic ☐ Hindu ☐ Islam ☐ Jewish ☐ Protestant ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

PRIMARY LANGUAGE

PHARMACY

PHARMACY NAME

ADDRESS / LOCATION

ZIP

PHONE

FAX

ALL APPOINTMENT UPDATES WILL BE SENT TO YOUR CELL PHONE OR EMAIL

PATIENT / GUARDIAN SIGNATURE

DATE

PATIENT NAME

TODAY'S DATE

REASON FOR TODAY'S VISIT

DRUG ALLERGIES (LIST, OR WRITE NKDA)

PREVIOUS HOSPITALIZATIONS, SURGERIES & SERIOUS INJURIES

DESCRIPTION	DATE

CURRENT MEDICATIONS

MEDICATION	DOSAGE	DIRECTIONS

SOCIAL HISTORY

ALCOHOL USE ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

TOBACCO USE ☐ Never ☐ Previously ☐ Current QUIT DATE PACKS / DAY (CURRENT)

DRUG USE ☐ Never ☐ Yes TYPE / FREQUENCY (IF APPLICABLE)

EXPOSURE TO ☐ Fumes ☐ Airborne Particles ☐ Solvents ☐ Dust ☐ Noise

HISTORY OF DOMESTIC VIOLENCE ☐ Physical ☐ Verbal ☐ Other

PATIENT NAME

TODAY'S DATE

FAMILY HISTORY

Father			
Mother			
Siblings			
Spouse			
Children			

PHYSICIAN REVIEWED (INITIALS)

DATE

PATIENT SIGNATURE

DATE

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, (PATIENT NAME)

hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices, explaining how this office will use and disclose my protected health information, my privacy rights with regard to that information, and this office's obligations concerning its use and disclosure.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised notice upon request. If I have any questions or complaints, I understand I may contact this office, or the Secretary of the U.S. Department of Health and Human Services, regarding our privacy and security policies and procedures.

PATIENT OR PERSONAL REPRESENTATIVE

SIGNATURE

DATE

NAME (PLEASE PRINT)

RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

We made a good-faith effort to obtain a signed acknowledgment of receipt of our Notice of Privacy Practices. In spite of these efforts, our office was unable to obtain a signed acknowledgment for the following reason(s):

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining an acknowledgment
- ☐ An emergency situation prevented us from obtaining an acknowledgment
- ☐ Other

ATTEMPT MADE BY (STAFF)

DATE