Intercare Clinic
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

REGISTRATION FORM

Date: _____

PATIENT INFORMATION:
First Name: _____Middle Name:_____Last Name:_____
DOB: _____/____/_____ Social Security Number: _____-____-_____ Sex: M F
Marital Status:Single.-.Married.-.Divorced.-.Separated.-.Widow Preferred language: English.-.Spanish.-.French.-.Creole
Race:_____ Ethinicity:_____Occupation: _____

PATIENT ADDRESS:_____Apt/Bldg/Condo #:_____
City:_____State:_____Zip code:_____
Mobile Number:(_____)-_____-_____Home:(_____)-_____-_____Work:(_____)-_____-_____
Email address: _____

EMRGENCY CONTACT
Name: _____Relationship: _____Phone #:(_____)-_____-_____

EMPLOYMENT INFORMATION
Are you: Employed.-. Student.-. Self-Emploeyed.-. Retired.-. Disabled.-. Unemployed.
Employer/ School Name:_____
Address: _____City:_____State:_____Zip Code:_____
Phone Number:(_____)-_____-_____ Email:_____

BILLING AND INSURANCE INFORMATION
Do you have Insurance. NO YES (If yes, complete below)
Insurance name:_____Policy:_____Group:_____
Insurance phone number: (_____)-_____-_____Fax: (_____)-_____-_____
Incurance Address: _____City:_____Zip code:_____
Insured name (Guarantor):_____ DOB: _____SSN:_____-____-_____
Relationship to the Insured: _____

Secondary Insurance name: _____Policy: _____Group:_____
Insurance phone number: (_____)-_____-_____Fax: (_____)-_____-_____
Incurance Address: _____City:_____Zip code:_____
Insured name (Guarantor):_____ DOB: _____SSN:_____-____-_____
Relationship to the Insured: _____

The above information is true to the best of my knowledge.- I authorize my insurance benefits be paid directly to my physiscian. I understand that I am responsible for any balances.

_____ _____
Patient Name Print Parent /Legal Guardian

_____ _____
Patient Signature Date

Intercare Clinic
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

POLICIES AND PROCEDURES

Thank you for choosing Intercare Clinic. We are committed to build a successful porvider-patient relationship.

HOURS OF OPERATION

We open Monday thru Friday: 9:00am – 5:00pm.- ***closed for lunch from 1:00pm to 2:00pm.*** Closed on ***WEDNESDAY AND WEEKEND***

POLICIES OF OPERATION

- If you are more than 15 minutes late for your appointment we will make every effort to work you in if the schedule permits. However you may be asked to reschedule for a later date.
- Prescription refills will be provided at scheduled appointments in quantities sufficient to last until your next scheduled appointment. Please remind us at your appointment if you will need refills.
- NO REFILLS will be provided if you have not been to the office for more than three months.
- At no time will controlled substance prescriptions be called in. You must be seen at scheduled appointments for refills.
- If you are un-insured payment is due at time of service.
- Forms will be completed by the provider as time allows at a charge of $25.00 per page

PAYMENT

Understand that charges not covered by insurance company, as well as applicable copayments and deductibles, are your responsibility. Therefore, you will authorize your insurance benefits be paid directly to Intercare Clinic

Please understand that payment of your bill is part of this treatment and care.

APPOINTMENT

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient.

We understand situations arise, and require to cancel an appointment. We request you give our office a 24- hour notice in the event you need to reschedule/ cancel your appointment or you will be ***charged a $25 fee on your next appointment and will not be covered by your insurance.***

I have read and understand the above policies, procedures and financial responsibilities, and agree to abide by this policy in exchange for quality medical care.

_____ _____

Patient Name Print Date

_____

Patient Signature

Intercare Clinic
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy provides information about how we use and disclose Protected Health Information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice you may obtain a revised copy contacting our office

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, 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, signed by you. However, such a revocation shall not affect any disclosures we have already, made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance and Accountability Act of 1996 (HIPAA).

I _____, hereby give my consent for Intercare Clinic to use and
(Print Name)
disclose Protected health Information

_____ _____
Patient Name Print Parent/ Guardian Name

_____ _____
Patient Signature and date Parent/Guardian Signature and date

PROTECTED HEALTH INFORMATION AUTHORIZATION (Optional)

Please fill the portion below if you give the permission to our office to discuss/ release you medical information with designated family or significant other.

Name of desiganted person:_____ DOB:_____
Relationship :_____ Phone number:(_____)-_____-_____

By Signing this portion, I _____authorize Intercare Clinic to release, discuss My medical Information to _____.

_____ _____
Patient Name Print Date

_____ _____
Patient Signature Designated person Signature (if present)

Intercare Clinic
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____hereby request and give my permission to _____to release healthcare information of the patient named above to:

INTERCARE CLINIC
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

This request and authorzation applies to:

- Healthcare information relating to the following treatment condition or dates:_____
- All healthcare information
- Other:_____
  _____
  _____

_____ _____
Patient Name Print Date

_____
Patient Signature

_____ _____
Parent/ Legal Guardian name Date

_____
Parent/Legal Guardian Name

Intercare Clinic
Humaira Khan, M.D., P.A.
4850 W Oakland Park Blvd, Ste 115
Lauderdale Lakes, Fl 33313
Phone: 954-486-8663.- Fax: 954-486-8979

LIVING WILL

Declaration made this _____ day of _____ 201_____
I, _____,willfully and voluntarily make known my desire that my dying not be artificially prolonged under the following circumstances. And I do hereby declare that, if at any time, I am both mentally and physically incapacitated,

_____ and I have a terminal condition;
Or _____ I have an end-stage condition;
Or _____ I am in a persistent vegetative state.

And if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I would be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding withdrawal, or continuation of life-prolonging procedures, I wish to designate the following person as my surrogate to carry out the provisions of this declaration.

Name: _____ Phone number: (_____)-_____-_____
Address: _____City: _____ State: _____Zip code: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):
_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Witness Name Witness Signature and date

_____ _____
Witness Name Witness Signature and date

PATIENT DECIDED NOT TO FILL DOCUMENT
Patient Initial _____ Date: _____