INTERCARE CLINIC HUMAIRA KHAN, MD
4850 W. Oakland Park Blvd. Ste 115
Lauderdale Lakes, FL 33313
Tel: 954-486-8663 Fax: 954-486-8979

PLEASE READ AND FILL IN ALL INFORMATION IN ITS ENTIRETY

THIS INFORMATION IS REQUIRED BY YOUR INSURANCE COMPANY

ALL PAGES MUST BE SIGNED AND DATED

APPOINTMENT & REFERRAL POLICIES

24HR CANCELLATION NOTICE IS REQUIRED

OR THERE WILL BE A CHARGE OF $50.00 NO EXCEPTIONS

REFERRALS REQUIRE*48 HOUR NOTICE* – NO EXECPTIONS

PLEASE INITIAL THIS PAGE: _____ **DATE** _____

FINANCIAL POLICY AND PROCEDURE

I hereby give authorization for payment of insurance benefits to be made directly to Humaira Khan MD fo services rendered.

In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original.

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

RESPONSIBILITY FOR PAYMENT:

The patient his or her parent or guardian, or person or agency requesting treatment is fully responsible for all charges incurred. Every effort will be made to verify insurance eligibility and benefi coverage. However, insurance seldom covers the entire fee and the patient is responsible for his/her cost (Co-Pay) at each session.

MISSED APPOINTMENT POLICY:**

Policy for Cancelling your appointment. All appointments must **be cancelled at least 24 hours prior to the scheduled appointment.** Failure to cancel or attend appointments will result in a **$50.00 charge.** This can NOT be charged to your insurance company.

EMERGENCY SERVICES:

In an emergency you may call **911** or go to the nearest emergency room to be evaluated. Only emergency messages will be forwarded to Dr. H. Khan, other messages may not be able to be returne until the office is once again open. All patients should contact their pharmacies directly for all refills.

Signature: _____ Date: _____

PATIENT INFORMATION RECORD

PATIENTS LEGAL NAME: _____ **DOB** _____

EMAIL: _____ **TODAY'S DATE:** _____

CELL PHONE: _____ **HOME PHONE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP:** _____

SS# _____ **SEX:** (circle one) Male _____ Female _____ Other _____

EMERGENCY/NAME PHONE: _____

BELOW CIRCLE ONE IN EACH CATEGORY

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: (Please note your primary language)_____

PHARMACY: NAME: _____

ADDRESS/LOCATION _____

ZIP _____ PHONE _____ FAX _____

INSURANCE: (circle one) HMO PPO MEDICARE OTHER: _____

PERSON RESPONSIBLE: _____

RELATIONSHIP TO INSURED: _____

EMPLOYER: _____

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

SIGNATURE: _____ **DATE:** _____

PATIENT HISTORY FORM	Patient Name:				Date:	
It is helpful to gather information about your medical history for the physician to use in your examination.						
EYES, EARS, NOSE, MOUTH				***CONSTITUTIONAL SYSTOMS***		
Hearing loss	No	Yes		Good general health lately	No	Yes
Hearing ringing	No	Yes		Recent weight change	No	Yes
Earaches or Drainage	No	Yes		Fever	No	Yes
Chronic sinus problem	No	Yes		Fatigue	No	Yes
Chronic sinus rhinitis	No	Yes		Headaches	No	Yes
Nose Bleeds	No	Yes		***INTEGUMENTARY (skin breast)***		
Mouth Sores	No	Yes		Rash or itching	No	Yes
Bleeding gums	No	Yes		Change in skin color	No	Yes
Voice Change	No	Yes		Change in hair	No	Yes
Swollen glands in neck	No	Yes		Change in nails		
RESPIRATORY				Varicose Veins	No	Yes
Chronic or frequent coughs	No	Yes		Breast pain	No	Yes
Spitting up blood	No	Yes		Breast Lump	No	Yes
Shortness of breath	No	Yes		Breast discharge	No	Yes
Asthma or Wheezing	No	Yes		***CARDIOVASCULAR***		
MUSCULOSKELETAL				Heart trouble	No	Yes
Joint Pain	No	Yes		Chest pain or angina pectoris	No	Yes
Joint stiffness or swelling	No	Yes		Palpitation	No	Yes
Weakness of muscles or joints	No	Yes		Shortness of breath with walking	No	Yes
Muscle Pain or cramps	No	Yes		Swelling of feet, ankles or hands	No	Yes
Back Pain	No	Yes		**NEUROLOGICAL**		
Cold extremities	No	Yes		Frequent headaches	No	Yes
Difficulty in walking	No	Yes		Recurring headaches	No	Yes

Sports injury	No	Yes		Light headed or dizzy		
HEMATOLOGIC/LYMPHATIC				Convulsions or seizures	No	Yes
Slow to heal after cuts	No	Yes		Numbness or tingling sensations	No	Yes
Bleeding	No	Yes		Tremors	No	Yes
Bruising tendency	No	Yes		Paralysis	No	Yes
Anemia	No	Yes		Stroke	No	Yes
Phlebitis	No	Yes		Head injury	No	Yes
Past transfusion	No	Yes		***ENDOCRINE***		
Enlarged glands	No	Yes		Glandular or hormone problem	No	Yes
GASTROINTESTINAL				Thyroid disease	No	Yes
Loss of appetite	No	Yes		Diabetes	No	Yes
Change in bowel movements	No	Yes		(Insulin or non-insulin -Circle One)	No	Yes
Nausea or vomiting	No	Yes		Excessive thirst	No	Yes
Frequent diarrhea	No	Yes		Excessive urination	No	Yes
Constipation	No	Yes		Heat or cold intolerance	No	Yes
Rectal bleeding or blood in stool	No	Yes		Skin becoming dryer	No	Yes
Abdominal pain	No	Yes		Change in hat or glove size	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes		***PSYCHIATRIC***		
ALLERGIC/IMMUNOLOGIC				Memory loss	No	Yes
DRUG ALLERGIES: List Below				Confusion	No	Yes
				Nervousness	No	Yes
PATIENTS SIGNATURE:				Depression	No	Yes
Date:				Insomnia	No	Yes

PATIENT HISTORY FORM	Patient Name:		Date:
GENITOURINARY			**FEMALE**
Frequent urination	No	Yes	Pain with periods
Burning or painful urination	No	Yes	Use douche
Blood in urine	No	Yes	Irregular periods
Incontinence or dribbling	No	Yes	Vaginal discharge
Kidney Stones	No	Yes	Age at the onset of menstruation
Sexual difficulty	No	Yes	Number of days menstruation lasts:
Male - Testicle pain	No	Yes	Date of last menstrual period:
History of Prostate Problems: If YES please explain:	No	Yes	Date of last pap smear:
PAST MEDICAL HISTORY:			Miscarriages:

Previous Hospitalizations / Surgeries / Serious injuries: Dates:

MEDICATIONS	DOSAGE	DIRECTIONS

Patient Social History: CIRCLE ONE

Use of Alcohol:	NEVER		RARELY	DAILY		MODERATRE
Use of Tobacco:	PREVIOUSLY BUT QUITE WHEN:		NEVER	CURRENT PACKS PER DAY:		
Use of Drugs	NEVER	TYPE/FREQUENCY				
Marital Status:	SINGLE	S/O	MARRIED	DIVORCED	SEPERATED	WIDOWED
Exposure to:	FUMES	AIR-BORNE PARTICLE		SOLVENTS	DUST	NOISE
History of domestic violence:	PHYSICAL	VERBAL	OTHER			

Patient Social History:	AGE	DISEASES	IF DECEASED	CAUSE OF DEATH
FATHER				
MOTHER				
SIBLINGS				
SPOUSE				
CHILDREN				

PHYSICIAN REVIEWED: DATE:

PATIENT SIGNATURE: **DATE:**

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTIES NOTICEHIPAA

I, _____,

hereby acknowledge that I have reviewed and received a copy of this *Notice of Privacy Practices* explaining:

How this office will use and disclose my protected health information. My privacy rights with regard to my protected health information. This office's obligations concerning the use and disclosure of my protected health information.

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 of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concern with any concern regarding our privacy and security policies and procedures, Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative:	
Signature:	**Date:**
Name: (please Print)	
Relationship to Patient:	

For office use only:			
We made a good-faith effort to obtain an acknowledgment of Date:			
Receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed			
acknowledgment of receipt for the following reasons *(check all that apply)*:			
	☐		Patient refused to sign (date of refusal) **Date:** / /
	☐		Communications barriers prohibited obtaining an acknowledgment
	☐		An emergency situation prevented us from obtaining an acknowledgment
	☐		Other
Attempt was made by:			**Date:** / /