NORTHVILLE
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Abbasi Dermatology
the evolution of skincare

SAMI ABBASI, D.O.
DUAL BOARD CERTIFIED
ABBASIDERM.COM

BROWNSTOWN TWP.
19117 Allen Road, Suite A
Brownstown Twp, MI 48183
734.675.0835 Phone
734.675.0873 Fax

PATIENT INFORMATION

(Please Print) Today's Date _____/_____/_____

Name _____ SS# _____
Last *First* *M.I.*

Mailing Address _____
City *State* *Zip*

Home Phone (_____)_____ Cell Phone (_____)_____
Area Code *Area Code*

Sex: ❒ Male ❒ Female D.O.B. ___/___/_____ E-mail _____

Race _____ Ethnicity _____ Preferred Language _____

GUARANTOR INFORMATION

Name _____ D.O.B. ___/___/_____
Last *First* *M.I.*

Address _____
City *State* *Zip*

Phone (_____)_____
Area Code

EMERGENCY CONTACT

Name _____

Phone _____ Relationship to Patient _____

HIPAA QUESTIONNAIRE

1. In signing this notice, I, _____ am granting permission for this office to inquire or obtain information from my insurance company for treatment and billing purposes for myself and family members and to receive and/or forward necessary records if indicated in the case of a referral or transfer to another facility.

2. Please list the family members or other persons, if any, whom we may inform about your medical condition (including treatment and payment).

Name _____ Relationship _____

Name _____ Relationship _____

3. Please list the family member who is named legal representative (guardianship, foster care or medical power of attorney), whom we may inform and/or inquire about your medical condition given more extenuating circumstances:

_____ Contact number: _____

4. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?
YES____ NO____

Consent to Examination and Treatment

I understand and voluntarily consent to receive medical and health care services given by SAMI ABBASI, D.O., his associates or assistants. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations and treatments considered advisable or necessary in the judgment of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my Dermatologist. I hereby release my examiner from all responsibility in connection with the examination.

Cancelled or Missed Appointments

We are happy to re-schedule any appointment for you. We do request 24 hours notice. It is our aim to accommodate you, the patient, whenever possible. This means that we have patients eager to use your cancelled appointment time. We reserve the right to charge a cancellation fee for appointments not cancelled 24 hours in advance. We hope you, our valued patient, will cooperate in this simple request.

Financial Responsibility and Assignment of Benefits

INSURANCE BENEFITS: We encourage our patients to discuss fees with us prior to any major medical or surgical procedure. We will bill your insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. You should contact your insurance company if you are not aware of what your copayment is. If we have not received payment from your insurance company within 90 days of the date of service, you will be expected to pay the balance in full and collect from your insurance company. **You are responsible for all charges.** Should you fail to pay for services rendered, your account may be turned over to a collection agency or attorney for collection. Once your account is turned over to a collection agency or attorney, you shall be responsible for the full balance due plus an additional 30% of the current balance due to cover collection costs and/or attorney fees. Interest will accrue on accounts referred to an outside collection agency at a rate of 1.5% per month.

NO INSURANCE BENEFITS: For patients with no insurance or who receive cosmetic procedures, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangements are made in advance for a payment plan.

RELEASE OF INFORMATION: I hereby authorize SAMI ABBASI, D.O., his associates or assistants to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment. I hereby authorize my insurance benefits to be paid directly to SAMI ABBASI, D.O. If it becomes necessary to refer this account to a collection agency, I agree to pay collection costs, court costs, and reasonable attorney fees.

Missed Appointments/Late Cancellations

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge $30.00 for missed or late cancelled appointments and $60.00 for missed surgical appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Managed Care

If you are enrolled in a managed care insurance plan (i.e. HMO), you are responsible for obtaining your referral from your primary care physician and presenting it to our office at the time of the service.

Payment For Services Is Expected At The Time Of The Service

Payment is required at the time services are rendered unless other arrangements have been made in advance with a member of our office staff. This includes applicable coinsurance and copayments for participating insurance companies. Our practice **accepts cash, personal check, VISA, Mastercard and Discover. There will be a charge of $30.00 for returned checks.**

Patients with an outstanding balance of 90 days overdue must make arrangements for payment prior to scheduling appointments.

I certify that I have read this form and understand its contents.

_____ _____

Signature of Patient or Other Legally Authorized Person Date

_____ _____

Print Patient Name if different than above Date