Noorani Medical Center

"Compassionate, Convenient and Quality Care"

NEW PATIENT INFORMATION

_____ _____ _____

Last Name First Name MI

_____ _____

Mailing Address Apt #

_____ _____ _____

City State Zip Code

Contact Phone Number: (_____) _____

____/____/____ _____ Male / Female Marital Status: ☐M ☐S ☐D ☐W

Date of Birth Social Security Number (circle one)

E-mail Address: _____

Race: ☐Asian ☐Pacific/Hawaiian ☐Black/African American ☐White ☐Other ☐Decline

_____ (_____)_____

Local Pharmacy Local Pharmacy Number

_____ (_____)_____

Mail-Order Pharmacy Mail-Order Pharmacy Number

IN CASE OF EMERGENCY:

_____ _____ (_____) _____

Contact Name Relationship to Patient Contact Number

Please review and sign below to provide consent:

☐ I authorize Noorani Medical Center to obtain all prescription history from any external source for the purposes of my treatment.

☐ I authorize disclosure of necessary medical information to my insurance company to determine benefits payable to related services.

☐ I give Noorani Medical Center consent to perform medical treatment.

_____ _____ _____

Patient/Representative Signature Relationship Date

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Medications:

Medication	Dosage	Directions

Are you allergic to any medications?

_____

***Medical History*:**
Please list your medical diagnoses:

_____

Preventative Services (please list dates): ☐ I do not have preventative services history

Mammogram _____ Bone Density _____ Fasting Labs _____ PSA _____

Colonoscopy _____ FOBT _____ Eye Exam _____ Pap _____

Immunizations (please list dates): ☐ I do no not have any immunization history

Hepatitis _____ Influenza _____ Pneumococcal _____ Shingles _____

TDAP _____ Covid-19 _____

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Surgeries and Hospitalizations (please list dates):	
Type/Reason	Date

Family History (please list relationship):		
Bleeding Disorder _____	Cancer (type) _____	Dementia _____
Seizures _____	Suicide _____	COPD _____
Kidney Disease _____	Heart Attack _____	Thyroid Disease _____
Migraines _____	Diabetes _____	Stroke _____
Tuberculosis _____	Other _____	

Social History:

Lifestyle:

Is there someone that lives in your residence? Y / N

If yes, list name and relationship

Type of residence: ☐House ☐Apartment ☐Mobile Home

Durable Medical Equipment? ☐Wheelchair ☐Oxygen ☐Walker ☐Cane ☐Nebulizer ☐CPAP/BIPAP

Do you require assistance with the following? ☐Bathing ☐Grooming ☐Toilet Needs

Do you drive yourself to your appointments? Y / N If no, who does?

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Personal Habits:

Do you drink alcohol? Y / N If yes, how often?

_____

Have you ever used? ☐None ☐Marijuana ☐LSD ☐Heroin ☐Cocaine ☐Speed ☐Other

How much caffeine do you consume daily? ☐None ☐1-2 cups ☐3-4 cups ☐more than 4 cups

What is your occupation?

_____

Do you have children? Y / N How many?

_____

Do you have pets? Y/ N If yes, what kind?

_____

Tobacco History:

Do you smoke? Y / N

If yes, how many cigarettes per day? _____ If no, what year did you quit?_____

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PATIENT CONSENT FOR PELVIC/ RECTAL EXAMINATION

A Pelvic Examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involved the pelvis. It may be performed using any combination of modalities, which may include the healthcare provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____
(Patient Printed Name) authorize my treating healthcare provider, the employed and/or contracted medical personnel of the provider as deemed necessary by my treating physician, and the medical students and/or students receiving training as a healthcare provider who may be involved in my care, to perform a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from the provider in the future, and I hereby agree to acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a healthcare provider, medical student, or student receiving training as a healthcare provider employed by and/or contracted with the provider unless I revoke this consent in writing by hand delivering a copy of the revocation to the provider. By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

_____

Patient/ Legal Representative Signature Printed Name and Date

Nazneen Noorani, MD

_____

Physician/Provider Signature Printed Name and Date

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FINANCIAL RESPONSIBILITY FORM

At Noorani Medical Center, we strive to give you the best possible care. In order to serve that purpose, it is important that you understand the process of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours.

- *If you have had any changes in your insurance coverage, you must notify us.*

COYPAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment for each date of service. You are also responsible for your deductible. Your deductible amount is determined by your individual contract with your insurance carrier. We may not have information about your deductible amount, or how much of it has been met. You will be responsible for finding out all information prior to your appointment with our office. During the course of your care, your provider may order labs or other diagnostic testing. These test orders are based on your provider's opinion of medical necessity. It is your responsibility to know your insurance coverage as it relates to the ordered tests before you have the testing performed.

SELF PAYMENT/SELF-PAY

All cash patients and patients without valid insurance information or active insurance coverage are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at time of service until your insurance information is on file.

_____ _____/_____/_____

Patient/Representative Signature Date of Birth

_____ _____

Relationship Date

Noorani Medical Center

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CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____, hereby authorize NOORANI MEDICAL CENTER to release my healthcare information to the following:

1. _____ _____
   Name of party authorized to receive information Relationship to patient

   _____
   Phone number of above-named person

2. _____ _____
   Name of party authorized to receive information Relationship to patient

   _____
   Phone number of above-named person

I authorize the verbal release of information contained in my medical record via either telephone or face-to-face communications to the above-named individual(s). Unless otherwise indicated, my authorization includes the release of the following:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment
- Generic test results and/or related treatment.
- Other: _____

☐ By checking this box, I agree to allow messages containing personal health information on my answering machine. If this box is not checked, only brief, non-specific messages may be left.

This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release and that it is my right to inspect all information disclosed, if I so request.

_____ _____/_____/_____
Patient/Representative Signature Date of Birth

_____ _____
Relationship Date

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PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow – up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____/_____/_____

Patient/Representative Signature Date of Birth

_____ _____

Relationship Date

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Dear Patient,

Thank you for being a patient of Noorani Medical Center. It is our mission to be compassionate by adding convenience and providing quality care. We look forward to partnering with you to address your health concerns, and we will do all we can to enhance your medical care. To help you get the most out of this worthwhile investment, we would like to share a few of our policies:

Please initials each section.

_____ **Clinic Hours:** The office is open Monday – Friday from 7:30am – 4:00pm; Tuesday and Thursday the office remains open until 6 pm. Phone lines are open Monday–Friday from 8am – 4pm.

_____ **Appointment Policy:** We will make every effort to see you at your scheduled appointment time. To minimize delays and ensure that each patient is seen at their scheduled time, your appointment may need to be re-scheduled if you are over 15 minutes late. Our office will call you one business day in advance to remind you of your scheduled appointment.

_____ **No-Show:** If you do not show for your appointment or do not provide 24-hour notice of a cancellation or reschedule, you will be charged a fee of $25. A pattern of no-shows may result in discharge from the practice.

_____ **After Hours:** Please call us during normal phone hours for any non-urgent matters. Medication refills, appointment requests, or other non-urgent matters will not be addressed outside normal phone hours. If your need is urgent, please call the office and you will be connected to the answering service.

_____ **Medications:** Bring all your medications (prescribed and OTC) to each office visit. You are responsible to know when your medications are due to be refilled. Some medications may require an appointment to be refilled. Please make any refills requests through the patient portal, it might take between 3-5 business days for us to process your request.

_____ **Referrals:** If your insurance company requires specialist referrals or authorizations, please request them at least 5 business days in advance. Please note, surgery or out-of-network authorizations may take up to 14 days for processing, depending on your insurance company's policies.

_____ **Forms and letters:** An appointment may be needed to meet the requirements of the paperwork. Please note, the completion of the paperwork can take up to 7 business days.

_____ **Medical Records:** The medical chart is property of the Practice. However, copies of your pertinent medical information are available upon request. The Practice may charge a copying fee per federal and state laws.

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_____ **Patient Information:** Please provide your full name, mailing address, phone number, email address, insurance information, and photo id at time of registration. Please update our office whenever your information changes.

_____ **Labs:** For your convenience, we offer blood draw in our office. We will forward your specimen(s) to Quest or Labcorp for testing. Copayments and deductibles might apply to your lab visit. Please call your insurance to verify if copayments and deductibles apply to blood draw.

_____ **Payments**: All copayments, deductibles, and outstanding balances will be collected at time of service. We gladly accept cash and credit cards, as well as checks under $50. NSF checks will result in a $25 returned-check fee plus the amount of the check.

_____ **Patient Discharge:** The Practice reserves the right to discharge a patient for any reason. Discharge may occur for failure to meet your obligations under this document. The Practice may discharge for failure to comply with treatment plan(s) as outlined by your provider.

_____ **Auto Accident/Workers' Compensation:** We do not treat conditions related to auto accidents or workers' compensation.

_____ _____/_____/_____

Patient/Representative Signature Date of Birth

_____ _____

Relationship Date

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CONSENT FOR TREATMENT OF MINORS

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Please be advised, a minor child (under 18) will not be treated without a parent/ legal guardian present. Please sign the first authorization below to allow us to care for your child.

Patient Name: _____ DOB: _____

Authorization to Treat a Minor Patient When Accompanied by Parent/Legal Guardian

I, _____, authorize and consent to the above-named patient receiving medical, immunizations or other healthcare treatment as is considered necessary by Noorani Medical Center.

_____ _____

Parent/Guardian Signature Date