



Zohra F. Siddiqi, D.O., P.A.

**Diplomate of American Board of Family Medicine & Functional
Medicine 410 Genesis, Suite-C Webster, TX 77598**

Financial Policy

Copayments, Coinsurance, deductibles and outstanding balances are expected at the time of service. We do not accept checks.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to transfer all associated financial liability for the claim to the guarantor. Failure to promptly resolve the financial obligation will result in third party collection and/or legal action.

It is the patient's responsibility to inform Dr. Zohra F Siddiqi's staff of any change in name, insurance, phone number, or other important information relating to the payment. Failure to do so may result in penalty fees or nonpayment by insurance.

If you do not show up for an appointment without 24 hour notice or reschedule your appointment without a 24 hour notice you will be charged a \$100 fee and a \$200 Functional Medicine No Show fee.

All paperwork must be fully submitted 24 hrs prior to appt.

Guarantor/ patient

Signature: _____

Print Name: _____



PATIENT INFORMATION

Today's date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: _____ Age: _____ Sex: _____ Cell Phone No.: _____

Street address: _____ Social Security no.: _____ Home phone no.: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____

Other family members seen here: _____

How did you hear about us? _____

INSURANCE INFORMATION

IF YOUR NEW BORN IS UNDER YOUR INS. PLEASE PUT YOUR INFO. HERE _____ (PLEASE GIVE OFFICE YOUR INS. CARD)

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Home phone/Cell phone: _____
_____/_____/_____ (____)_____

Primary insurance Name : _____

Member ID : _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: _____ Group no.: _____ Co-payment: _____
_____/_____/_____ \$ _____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

IN CASE OF EMERGENCY

Name of local friend or relative _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____
_____ () _____ ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____

Date _____

Patient Information Verification

Patient Name: _____

Date of Birth: _____

Please provide us with the phone numbers that you would like for us to call regarding your test results. If you are unavailable, a message may be left for you to return our call.

1. _____ Can we leave a detailed message Y or N
2. _____ Can we leave a detailed message Y or N
3. _____ Can we leave a detailed message Y or N

Please list the person(s), if any, with whom we may discuss your medical conditions and test results. (If no one listed will not be able to discuss any medical information)

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Please be advised that we will attempt to contact you via phone, an email will be sent if no VM is set up, with all test results, whether normal or abnormal. If you have not heard from us within two (2) weeks for labs and x-ray studies, or within two (2) weeks for pap smears and biopsies, please contact our office at 281-724-1271.

* Please sign up W/ PATIENT FUSION for access to medical record.

Patient (or Responsible Party) Signature: _____

Date: _____ Email: _____

Consent to Treatment

I consent to the procedures which may be performed during this outpatient visit, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, diagnostic procedures, blood and/or urine specimens for substance abuse (drug/alcohol) screenings, x-ray examination, medical or nursing treatment or other physician or clinic services rendered to me as ordered by my physician or other healthcare professional.

This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes.

Agree _____ Disagree _____ (initials)

Notice of Privacy Practices

I acknowledge that the medical privacy is in compliance with HIPPA regulations with regards to the ways in which the medical practice uses or discloses my healthcare information for treatment, payment, healthcare operations and others described and permitted uses and disclosures. I understand that I may reference www.hhs.gov/ocr/privacy/hippa if I have a question.

Acknowledge: _____ (initials)

I, as the patient, parent, guardian, spouse, guarantor or agent of the patient, certify that I have read, or have read to me, and understand this Consent to treatment. I have signed this Consent to Treatment knowingly, freely, and voluntarily. I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

Patient or Patient's Legal Representative Signature: _____

Print Name: _____

Date: _____

If signed by other than patient, indicate relationship: _____

Authorized representative must submit copies of legal document supporting his or her authority to act on the patients behalf

Witness Signature: _____

Witness Name: _____ Email: _____

Date: _____