FAMILY MED-SURG CLINIC
AYAD ALSAADI, MD.
Internal Medicine/Board Certified

10721 Main Street
Suite 2100
Fairfax, VA 22030

Patient Registration Form

Date: _____

▪ Patient Information

First Name: _____

Middle Initial _____

Last Name: _____

Gender: Male: ____ Female: ____

Date of Birth: _____ Age: _____

Marital Status: _____ Race: _____

Ethnicity: Hispanic: _____ Non-Hispanic: _____

Nationality: _____ Language: _____

SSN: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____

Cell: (_____) _____

Work: (_____) _____

Best number to reach you at: H _____, C _____, W _____

E-Mail: _____

How did you hear about us?

Insurance Co: ____ Internet: ____ Friend/Family: ____ Walk in: ____

Yellow Pages: ____ Post Card: ____ Other: _____

Parent/Guardian: If patient under 18 years of age.

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____

Cell: (_____) _____

Work: (_____) _____

SSN: _____ DOB: _____

Relationship to patient: _____

Emergency Contact

Name: _____ Relation: _____

Phone: (_____) _____

Pharmacy: _____ phone: (_____)_____ Pharmacy address: _____

▪ Insurance Information

Primary Insurance: _____

Policy Holder: First Name: _____

Middle Initial: _____

Last Name: _____

DOB: _____

SSN: _____

Relationship to Patient: _____

Member ID: _____

Group Number: _____

Insurance Co Address: _____

Employer: _____

Secondary Insurance: _____

Policy Holder: First Name: _____

Middle Initial: _____

Last Name: _____

DOB: _____

SSN: _____

Relationship to Patient: _____

Member ID: _____

Group Number: _____

Insurance Co Address: _____

Employer: _____

Important Information, Please Read:

Family Med-Surg Clinic accepts most insurance assignments. As a courtesy to you, we will complete the insurance form so that we will be reimbursed directly from your insurance company. The insurance companies are only obliged to you, "THE PATIENT" not to the physician. However, if we are not paid within (4) weeks or in a timely manner from your insurance, we will bill you directly and expect payment within twenty (20) days. You are expected and required to make a partial payment for services not covered by your insurance company at the end of your visit. Most companies will pay about 80% of the bill, AFTER YOUR CALENDER DEDUCTABLE HAS BEEN MET, leaving you responsible for the remaining 20%. Those patients without insurance are required to pay the balance in full on the date of service. This is required and is our office policy. Those patients who receive three bills without making a payment will then be sent to our Authorized Collection Agency. We charge 25 dollars for returned/cancelled checks and 25 dollars for not cancelling the appointment within a 24 hour notice period. All prescription refill requests will be processed within 48 hours if deemed appropriate by your physician otherwise you will be notified if you need to come back for a follow up appointment before refilling your prescription(s). We are glad to answer any question you may have concerning your visits and payments. If you are having financial difficulties, contact our office and we will arrange a personal payment plan that will meet both of our needs.

- I hereby authorize Family Med-Surg Clinic to furnish information to my insurance company concerning illness and treatment of myself and/or my dependents. I hereby assign benefits provided by my insurance company to the physician rendering these services. I further consent that I authorize to be treated by the physicians and medical staff within Family Med-Surg Clinic. I understand that I am responsible for any patient charges not covered by my insurance.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Name: _____

- I hereby authorize Family Med-Surg Clinic, to release my protected health information as described below: (check appropriate boxes)

Yes [ ]	No [ ]	Complete Medical Records
Yes [ ]	No [ ]	History and Physical Examination
Yes [ ]	No [ ]	Test results: Labs, X-rays, ECG, etc…
Yes [ ]	No [ ]	other, indicate:

Release the above records to: _____

This authorization is effective until I revoke it in writing

Patient/Guardian Signature: _____ Date: _____

- **Notice of Privacy Practices: Acknowledgement of Receipt**

I have received the "Notice of Privacy Practices" and I have been provided an opportunity to review it:

Patient/Guardian Signature: _____ Date: _____