



**Patient Consent to Use and Disclosure of Health Information  
For Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my healthcare, **MAHMOOD A.KHAN, MD** 's office originates and maintains papers and /or electronic records describing my health history, symptoms and examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can testify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of the healthcare professionals.

I understand and have been provided with *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation

I understand that **MAHMOOD A.KHAN, MD** 's office is not required to agree to the restriction requested. I understand that I am revoking this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand the **MAHMOOD A.KHAN, MD** 's office reserves the right to change their notice and practices prior to implementation. in accordance with Section 164.520 of the Code of Federal Regulations. Should **MAHMOOD A. KHAN, MD** office change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Who else do you give authorization to receive your medical information?

Name \_\_\_\_\_ D.O.B: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

**FOR OFFICE USE ONLY**

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on \_\_\_\_\_.

## HEALTH HISTORY (CONFIDENTIAL)

Name \_\_\_\_\_ Gender  M  F Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last physical examination: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Pharmacy : \_\_\_\_\_ Tel: \_\_\_\_\_

**SYMPTOMS: Check (x) symptoms you currently have or have had in the past year**

General	Gastrointestinal	Eye, Ear, Nose, Throat	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite Poor	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Lump in Testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sore on Penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other _____
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear Discharge	<b>WOMEN only</b>
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Hot Flashes
<b>Muscle/Joint/Bone</b>	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Nipple Discharge
<b>Pain, weakness, numbness in:</b>	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Arms	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Vision - Flashes	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Back <input type="checkbox"/> Legs	<b>Cardiovascular</b>	<input type="checkbox"/> Vision - Halos	Other _____
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> Chest Pain	<b>Skin</b>	<input type="checkbox"/> LMP Date _____
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Date of last Pap Smear _____
<b>Genito-Urinary</b>	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Hives	<input type="checkbox"/> Have You Had A _____
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Itching	<input type="checkbox"/> Mammogram? _____
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Change in Moles	<input type="checkbox"/> Are You Pregnant? _____
<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Rash	<input type="checkbox"/> Number of Children _____
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Scars	
	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Sore that won't heal	

**CONDITIONS: Check (x) conditions you now have or have had in the past.**

<input type="checkbox"/> Aids	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HTV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease

**ALLERGIES TO MEDICATIONS or Substances** \_\_\_\_\_



**THE OFFICE OF  
MAHMOOD A. KHAN, MD**

## **FINANCIAL POLICY**

**WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.**

### **INFORMATION REGARDING YOUR INSURANCE COVERAGE**

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

### **UNINSURED PATIENTS**

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

### **NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS**

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: In certain rare circumstances - and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.)

### **PARTICIPATING PROVIDER AND COVERED BENEFITS**

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

### **TYPES OF PAYMENT; DISHONORED CHECKS**

Our office accepts cash or personal checks, but we do not accept credit cards. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of Thirty-Five Dollars (\$35), which shall be due and owing immediately.

### **COLLECTION OF OUTSTANDING BALANCES**

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at

the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

**MISSED APPOINTMENTS**

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail. Your failure to cancel an appointment in a timely manner (i.e., at least 24 hours prior to the visit) deprives other patients of an opportunity to visit our office. You will be responsible for a paying a missed appointment fee of Twenty-Five Dollars (\$25) if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. We recognize the fact that there may be circumstances which may not permit you to give us 24 hours prior notice but such circumstances are exceptional and extremely infrequent and shall be considered on a case to case basis.

**RELEASE OF MEDICAL RECORDS**

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with New York law, we charge a photocopying fee of 75 cents per page, with a minimum fee of Ten Dollars (\$10) and have up to Ten (10) days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

**MISCELLANEOUS FEES**

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

**By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.**

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**Signature of Patient or Responsible Party**

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**Print Name of Patient and Responsible Party (if any)**

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**Date**