

ATA AHMAD, M.D. P.A.
PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (First, M.I. Last) _____

Date of Birth _____ Age _____ Male/Female Marital Status: S M W D

Address _____

Phone _____ Driver's License # _____

Employer _____

Employer Address _____

If Student, School Name _____ Full-Time/Part-Time

Responsible Party

Name _____ Relationship to Patient _____

Address _____ Phone _____

Employer _____ Phone _____

Employer Address _____

Emergency Contact _____ Phone _____

Insurance Information

Insurance Company _____ Phone _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone _____

Employer Address _____

Date of Birth _____ Male / Female

I hereby assign, transfer, and set over to ATA AHMAD M.D. P.A. to my medical reimbursement benefits under my Insurance policy for medical services rendered. I authorize the release of any medical information needed to determine these benefits. The authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether they are covered by insurance.

Patient Signature _____ Date _____

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ATA AHMAD M.D., P.A.

• Dr. Ata Ahmad •

Medication List

Patient Name: _____ D.O.B: _____

Allergies: _____

Medication Name	Dose	Frequency	Ordering Doctor
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Patient Signature: _____ Date: _____

ATA AHMAD, M.D. P.A.

Medical History

Name: _____ Social Security #: _____

Email: _____ Pharmacy Name & Location: _____

Primary Care Physician: _____ Referring Physician: _____

Home Number: _____ Alt: _____

Ethnicity: (Please circle ONE)

American Indian Asian Native Hawaiian Black/African American White Hispanic

Other: _____

Past Medical History:

High Blood Pressure

Asthma

Heart Attack

Diabetes

Bleeding Episode

High Cholesterol

Stroke

Stomach Ulcer

Thyroid Problems

Other: _____

Date of last performed Colonoscopy & Mammography:

Please list all past hospitalizations, operations, and injuries:

Year	Type of Illness	Hospital	City

Medication Allergies: Penicillin Codeine Sulfa Lidocaine Iodine Adhesive Tape Anti Inflammatory Others: _____

Social History: Tobacco Use Alcohol Use Drug Use

(Please answer the following ONLY if you smoke)

- How often do you smoke? Every Day or Somedays
- How many cigarettes a day? 5 or less 6-10 11-20 21-30 31 or more
- How soon after waking up do you smoke? Within 5 minutes 6-30 min 31-60 min after 60 min
- Are you interested in quitting? Ready to quit Thinking about Quitting Not ready to Quit

Family History:

Family Member	Current Health Status	Cancer History
Mother	Good/Poor/Deceased	Breast/Colon
Father	Good/Poor/Deceased	Breast/Colon
Grandmother	Good/Poor/Deceased	Breast/Colon
Grandfather	Good/Poor/Deceased	Breast/Colon
Siblings	Good/Poor/Deceased	Breast/Colon

Vaccines:

FLU VACCINE: YES / NO _____ COVID19 VACCINE: YES / NO _____
Dates Given _____ Dates Given _____

PNEUMOCOCCAL VACCINE: YES / NO _____
If No, what is the reason _____

For patients 65 or older:

I have fallen in the past year. YES NO

Nausea	<input type="radio"/> YES	<input type="radio"/> NO
Abdominal Pain	<input type="radio"/> YES	<input type="radio"/> NO
Diarrhea	<input type="radio"/> YES	<input type="radio"/> NO
Blood in Stool	<input type="radio"/> YES	<input type="radio"/> NO
Heartburn	<input type="radio"/> YES	<input type="radio"/> NO
Heart Attack	<input type="radio"/> YES	<input type="radio"/> NO
Shortness of Breath	<input type="radio"/> YES	<input type="radio"/> NO
Pneumonia	<input type="radio"/> YES	<input type="radio"/> NO
Asthma	<input type="radio"/> YES	<input type="radio"/> NO
Emphysema	<input type="radio"/> YES	<input type="radio"/> NO
Seizures	<input type="radio"/> YES	<input type="radio"/> NO
Thyroid Disease	<input type="radio"/> YES	<input type="radio"/> NO
Diabetes	<input type="radio"/> YES	<input type="radio"/> NO
Morbid Obesity	<input type="radio"/> YES	<input type="radio"/> NO
Painful Joints	<input type="radio"/> YES	<input type="radio"/> NO
Kidney Infection	<input type="radio"/> YES	<input type="radio"/> NO
Kidney Stones	<input type="radio"/> YES	<input type="radio"/> NO
Immune Disease	<input type="radio"/> YES	<input type="radio"/> NO
Allergy to food, plants, animals	<input type="radio"/> YES	<input type="radio"/> NO
Change in Appetite	<input type="radio"/> YES	<input type="radio"/> NO
Fatigue	<input type="radio"/> YES	<input type="radio"/> NO
Fever	<input type="radio"/> YES	<input type="radio"/> NO
Anxiety	<input type="radio"/> YES	<input type="radio"/> NO
Depressed Mood	<input type="radio"/> YES	<input type="radio"/> NO

ATA AHMAD, M.D. P.A

OFFICE POLICY

AUTHORIZATION TO TREAT:

I hereby grant permission to the authorities of ATA AHMAD, M.D. P.A. and the medical staff to perform such medical and/or surgical procedures they deem necessary. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/ treatment(s). I understand that should I leave the practice or a facility without written consent of my attending physician, I hereby relieve said physician and the practice of all responsibility of my action.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

I agree that the facility, ATA AHMAD, M.D.P. A., or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001 and related state regulations and statutes. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using email at any email address I provide to the facility or is otherwise associated with my account.

PATIENT AUTHORIZATION TO OBTAIN SUMMARY PLAN DESCRIPTION & 5500 FORM:

I hereby direct you to forward to ATA AHMAD, M.D. P.A. the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. **Summary Plan Description (SPD)**
2. **5500 Form (Plan Annual Report)**
3. **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address immediately:

Billing Manager
Ata Ahmad & Associates
11740 FM 1960 West Rd.
Houston, TX 77065

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

ATA AHMAD, M.D. P.A

FINANCIAL POLICY

FINANCIAL POLICY:

I have read and understand the Patient Financial policies, procedures, and authorizations of ATA AHMAD, M.D. P.A., including Payment Methods, Uninsured Accounts, Financial Responsibility resulting from insurance, insurance policy provisions, Diagnostic and Laboratory Testing, Collection Activities, Service Fees, Economic Hardship; Discharge of Patient, Out-of-Network, ERISA Plans, Final Cost of Services, and Authorizations to include Assignment of Benefits, Record Usage Provision, Consent for Medical Treatment, Consent to Use and Disclosure of Health Information for Treatment, Payment and Operations, Appointed Representative and Notice of Privacy Practices.

I understand that these policies, procedures, and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization in place.

ASSIGNMENT OF BENEFITS:

I certify that the information I have given to ATA AHMAD, M.D. P.A. is true and correct to the best of my knowledge and that I am responsible for keeping it updated. I promise to pay ATA AHMAD, M.D. P.A. to all charges and expenses for services provided to me by ATA AHMAD, M.D. P.A. in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to ATA AHMAD, M.D.P.A. I will personally be responsible for all charges for services that are not covered by my insurance carrier. I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and their Authorized Representatives. I agree to return any claim checks received from my health plan directly to ATA AHMAD, M.D. P.A. within three (3) days of receipt. I will endorse the check; Write Payable to "Ata Ahmad & Associates" and "For deposit only" under it. Send all correspondence to: Billing Manager, , 11740 FM 1960 W Rd, Houston, TX 77065

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including filing medical claims, appeals and grievances, institute litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims.

I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

ATA AHMAD, M.D. P.A.

HIPAA POLICY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby **authorize** the release of medical information (by telephone, mail, or otherwise) by physicians and staff of ATA AHMAD, M.D. P.A. to (please list name and relationship)

Name/Relationship

Address/Phone Number

I **DO NOT** authorize the release of medical information to my family members.

CONSENT FOR RELEASE OF PHOTOS/RADIOGRAPHS/VIDEOS FOR WEBSITE PUBLICATION

I hereby give permission to ATA AHMAD, M.D. P.A. to photograph, televise or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (videotape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.
I understand that no identifying information will be used

I **DO NOT** consent to the use of any pictures/videos/radiographs obtained during my treatment

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk or online at <https://ataahmadmd.com/>

I acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

*** You may refuse to sign this acknowledgment***

I refuse to sign this acknowledgment

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

PATIENT NOTICE & HIPAA POLICIES

Patients, please read the following:

1. **There will be a \$45.00 charge for No-Show appointments unless 24hr notice is given.**
2. Payment is expected at the time services are rendered unless prior financial arrangements have been made.
3. Please notify the front desk of any change in address, phone number or insurance coverage prior to your appointment. If you give us the information on the day of your appointment, you will have to wait until we can verify all the information, or you may need to reschedule.
4. It is your responsibility as a patient to make sure we have a valid referral for your visit, or you will be asked to pay for the visit in full.
5. **Test Results** will not be given over the phone. Results will be discussed with the patient when the patient returns for the follow-up visit.
6. **There is a \$45.00 fee for copies of medical records, FMLA forms, disability forms, and attending physician statements needing to be completed. This fee is waived for copies of records sent directly to another attending physician.**
7. Your medical information cannot be disclosed due to HIPAA. regulations unless you authorize this office to do so in writing. If you wish to have your spouse, partner, or significant other to obtain medical information: please write that person(s) name below. Please allow _____ access to my medical records, disclosure of my financial records. Relationship to patient _____.
_____ I do not wish to have any of my medical records, lab results, or disclosure of my records released except for me.
8. I understand that ATA AHMAD M.D. P.A. are not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
9. 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 wish to have the following restriction to the use or disclosure for my health information: _____

10. **There will be a \$300.00 charge for any No-Show and/or surgery cancellation without a notice of 24 HOURS.**

11. I understand I am financially responsible for the related charges or remaining charges following my insurance payments.

12. During some surgical procedures, ATA AHMAD M.D P.A. requires the use of a Surgical Assistant. Surgical Assistants are not employed by our practice and will bill their services to your insurance company directly. It is out of our control as to whether these assistants are in or out of network with your insurance carrier. Also, any hospital fees are separate from doctor's fee for surgery.

13. I authorize ATA AHMAD M.D P.A. to obtain any medical history information (i.e. medical history, surgical history, medications, family history, social history, prior diagnostics, lab reports) from active providers/facilities in order to provide the highest level of care.

14. Permission for treatment. I hereby authorize the physician to administer any treatment as may be deemed necessary. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of examinations or treatments to be performed by the physician or clinical personnel.

I have read and understand this Patient Notice and HIPAA policies.

Patient Signature

Date

ATA AHMAD, M.D. P.A.
GENERAL SURGEON

Phone No. (281) 970-8484

Fax No. (281) 970-8485

AUTHORIZATION FOR RELEASE OF PROTECTED RECORDS

I AUTHORIZE ATA AHMAD, M.D. P.A., 11740 FM 1960 Road West, Houston, Texas 77065 to:

release receive

PATIENT'S NAME: _____ DOB: _____

SOCIAL SECURITY: _____ DATE OF SERVICE: _____

INFROMATION TO BE RELEASED:

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Emergency Report
<input type="checkbox"/> Discharge Notes	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-Ray Report	<input type="checkbox"/> Autopsy Reports
<input type="checkbox"/> Progress Report	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Complete Report
<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other _____

This information is being released for the following purpose:

Continue Care Attorney / Litigation Insurance Disability Services
 Other _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here: _____

I understand that if the recipient authorized to receive the information is not a covered entity, i.e., Insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2, AUTHORIZATION TO RELEASE INFORMATION

Signature of Patient or Legally Authorized Representative

Date

Relationship to Patient

Print Name of Legally Authorized Representative

Witness - Printed Name / Signature

Date

Patient or Legally Authorized Representative Driver's License/ID#



Acknowledgement of Surgical Assistant

Please be informed that a Licensed/Certified Surgical Assistant "L/CSA" or a Physician Assistant "PA-C" may be required for your surgical procedure. Licensed/Certified Surgical Assistants and Physician Assistants are professional members of the healthcare team and are qualified by academic and clinical education to provide surgical assistance to the surgeon during your surgery.

The Licensed/Certified Surgical Assistant or Physician Assistant is critical during a surgical procedure, though in some cases they are deemed medically unnecessary by insurance companies. The necessity of a Licensed/Certified Surgical Assistant or Physician Assistant however is determined solely by the primary surgeon and deemed necessary for safe outcomes.

Universal Surgical Assistants requires that patients pay a \$300 deposit for ALL procedures, 2 business days before the surgery. Patient's will then be refunded any over payment after the insurance claim is finalized. All Medicare, Medicare Supplement, Medicare Replacement, Military, and Medicaid plans will deny payment as these insurance plans do not recognize Licensed/Certified Surgical Assistants regardless if it is the Surgeon's choice. Military, and Medicaid plans will deny payment as these insurance plans do not recognize Physician Assistants regardless if it is the Surgeon's choice. Claims will not be sent to these insurance providers; therefore, patients will be billed directly.

Senate Bill 1264 has been effective since January 1, 2020, which allows Licensed/Certified Surgical Assistant and or Physician Assistants to bill co-insurance and deductibles on fully funded and TRS plans. SB 1264 does not apply to self-funded employer sponsored health plans or Medicare. Universal Surgical Partners is in 100% billing compliance under SB 1264 guidelines. Beginning January 1, 2022 Title 1(No Surprises Act) of Division BB of the Consolidated Appropriations Act of 2021 the same rules will apply to self-funded plans.

Note: Most insurance companies consider Surgical Assistants as "Out-of-Network Providers" or do not contract with Licensed Surgical Assistants & Physician Assistants. Blue Star Surgical Assistants, Xcite Surgical, Universal MSO and Universal Surgical Assistants are subsidiaries of Universal Surgical Partners. You may receive a bill from either of these entities for the services performed. We wish you the best in your upcoming operative procedure.

For questions, please contact our office at 832-655-4141 or email us at Scheduling@USPartnersInc.com

Prepay at <https://pay.instamed.com/Form/PaymentPortal/Default?id=universalsurg>

I have read and acknowledge the above information.



Patient Signature: _____

Date: _____

Printed Name: _____

DOB: _____

Physician's Name: AHMAD

DOS: _____

Witness: _____

Phone: _____