GHASSAN N. FANOUS, M.D.

540 West 5th Street, Suite 420 Odessa, Texas 79761
(432) 582-2280

REGISTRATION FORM

PLEASE PRINT CLEARLY Date _____ Referred By _____

Pharmacy Preference _____

Reason For Visit _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile Phone _____

Soc. Sec. No. _____ Date of Birth _____ Age _____

Driver's License No. _____D.L. State _____ Marital Status: (please circle) Single - Married - Other

Employer Name _____ Address _____

City, State, Zip _____ Phone _____

Can we contact you your place of employment? _____ YES _____ NO

Spouse's Name _____ Date of Birth _____ Soc. Sec. No. _____

INSURANCE INFORMATION

Primary Insurance _____ Relation to Insured _____

Insured Full Name _____

Address _____ City, State, Zip _____

Soc. Sec. No. _____ Date of Birth _____

Employer Name _____ Address _____

City, State, Zip _____ Phone _____

Secondary Insurance _____

Emergency Contact* _____ Relationship _____ Phone _____

AUTHORIZATION TO RELEASE INFORMATION / PAY FOR SERVICES I hereby authorize Ghassan Fanous, M.D. to release any information required in the course of my examination or treatment. I hereby authorize payment directly to the business office of Ghassan Fanous, M.D. for the surgical and or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Patient Signature _____ Date _____

Revised: 8/14/2009

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS TO OR FROM MEDICAL PROVIDERS

I hereby authorize Dr. Fanous to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize Dr. Fanous to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize Dr. Fanous to release any and all medical records concerning my care to Medicare, Medicaid and Insurance Company, Third Party Administrator, or Managed Care Company.

_____ _____
Signature of Patient Date

_____ _____
Patient Name (please print) Social Security Number

AUTHORIZATION TO RELEASE MEDICAL INFORMATION INDIVIDUALS / FAMIL Y MEMBER

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Dr. Fanous or staff to discuss your condition with members of your family or other individuals that you designate, we must obtain authorization due to the severity of your medical condition, the law stipulated that these rules may be waived.

_____ I ***do not*** authorize Dr. Fanous to release any or all information concerning my medical care to any individual except as set forth above.

_____ I ***authorize*** Dr. Fanous to verbally release any or all information concerning my medical care to the following individuals:

_____ _____
Name Relation to Patient

_____ _____
Name Relation to Patient

_____ _____
Signature of Patient Date

Revised: 8/14/2009

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IF YOU *HAVE* INSURANCE READ AND SIGN

PRIVATE INSURANCE ONLY

I have informed Dr. Fanous' office staff that I only have private insurance, and that I have no other form of coverage. I understand that if I have any other coverage, or changes, it is my responsibility to notify the office.

This office will not file retro Medicaid.

Dr. Fanous will only file Medicaid two (2) weeks prior to the run date on the card I present. Any balance remaining, prior to that time, is my responsibility.

_____ _____

Signature of Patient Date

IF YOU HAVE *NO* INSURANCE READ AND SIGN

PRIVATE PAY PATIENTS

I understand that Dr. Fanous is accepting me as a private pay patient. I will be responsible for any services I receive, and his office will not file a claim to Medicaid for services provided to me. Payment will be due at time of service, unless prior arrangements have been made with the office manager.

_____ _____

Signature of Patient Date

Revised: 8/14/2009

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I understand that I have been accepted by Ghassan Fanous, M.D. as an insured or self pay patient. Dr. Fanous will NOT accept Medicaid as secondary to any private or commercial insurance nor will he accept Medicaid retroactively. I understand that by signing this waiver that I will be responsible for my deductible, co-pays, and any amount not covered by my insurance.

_____

Patient Signature

_____

Witness Signature

_____

Date

GHASSAN N. FANOUS, M.D.
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Acknowledgement of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPPA). Providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was reviewed.

Therefore, I ________________________ (printed name of patient or personal representative) acknowledge that **GHASSAN N. FANOUS, M.D.** has provided a written copy of the Notice of Privacy for Protected Health Information to myself or ______________________________ (specify if signing as a personal representative, documentation of your legal right to do so must be provided.)

______________________________________ ______________________

Signature of Patient / Representative Date

- -

TO BE COMPLETED BY GHASSAN FANOUS, M.D. OR STAFF MEMBER

We made a good faith attempt to provide the above named patient with a copy of Our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

____

____

____

______________________________________ ______________________

Signature Title

______________________________________ ______________________

Printed Name Date