

Raza Pasha, M.D., P.A.

## REGISTRATION UPDATE

Date \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
 Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ How and where did you learn about this clinic? \_\_\_\_\_  
 Last Name First Name Initial  
 Relationship To Insured  Self  Spouse  Child  Other  
 Condition/ Illness Related To  Illness  Employment  Auto  Other

<b>EMPLOYER</b>	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____ Years Employed _____
<b>SPOUSE (PARENT)</b>	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
<b>PATIENT INSURANCE INFORMATION</b>	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
<b>SPOUSE COINSURANCE INFORMATION</b>	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
<b>MEDICAL AND LEGAL INFORMATION</b>	<b>Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
<b>Patient Agreement &amp; Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing &amp; Reimbursement As Required by Federal and State Laws</b>	<b>Legal Assignment Of Benefits And Designation Of Authorized Representative</b> In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u> , all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.</u> I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.  _____ Signature of Insured / Guardian <span style="float: right;">_____</span> Date