Carol N Abalihi MD PA
3030 Joe Battle Ste. B
El Paso, TX 79938
Phone: 915-225-4470

Patient Registration

(Registración del Paciente)

Name: _____ **DOB**_____**M/F Marital Status S M W D SEP**
(Nombre) (Fecha De Nacimiento) (Sexo) (Estado Civil)

SSN: _____ **Email Address:** _____ **Student Yes/No**
(Seguro Social) (Correo Electrónico)(Estudiante)

Mailing Address:_____ **City/State/Zip:** _____
(Dirección) (Ciudad, Estado, Código Postal)

Main Phone #:_____ **Alternate Phone #:**_____
(Teléfono) (Alternativo)

Occupation/Employer:_____
(Ocupación/Empleador)

Race (Choose Only One) Caucasian African America Asian Hispanic Native American American Indian Alaskan Native Hawaiian More than one race Other:_____

Spouse Name:_____ **DOB:**_____ **SSN:**_____ **Phone:**_____
(Nombre de Esposa/o) (Fecha De Nacimiento) (Seguro Social) (Teléfono)

Emergency Contact:_____**Relation:**_____**Phone:**_____
(Contacto de Emergencia) (Relación) (Teléfono)

Reason for Visit:_____
(Razón de la visita)

Pharmacy:_____**Pharmacy Address:**_____
(Farmacia) (Dirección De La Farmacia)

Do you have an Advanced Directive? **Yes / No** **Do you smoke? Yes / No**
(Tiene una Directiva Anticipada) Si/ No(Fuma?) Si/ No

Patient Signature:_____
(Firma del Paciente)

PAYMENT IS REQUIRED AT THE TIME OF SERVICE
(EL PAGO ES REQUERIDO EN TIEMPO DE SERVICIO)

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RECORDS RELEASE AUTHORITY

DATE: _____

TO: _____
DOCTOR/HOSPITAL

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

__Entire Medical Record
__Operative Report
__Laboratory/Pathology Reports
__Radiology Reports
__Sleep Study Reports
__Substance Abuse/Dependency
__Psychiatry/Mental Health Treatment
__HIV/Aids Information
__Sexually Transmitted Disease Test/Treatment
__Other_____

Patient Name: _____
DOB: _____ SSN: _____ Date: _____
Patient Signature: _____
Witness/Office Staff: _____ Date: _____

PERSON REQUESTING MEDICAL RECORDS OTHER THAN THE PATIENT

Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

This consent is effective from today and will expire upon request. I understand that information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law.

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize Carol N Abalihi MD PA and its Affiliated Providers to view external prescription history via Rx Hub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefits manager may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE BELOW CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

SIGNATURE: _____

DATE: _____

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BILLING POLICY

- The following sets forth the general billing policy of Carol N Abalihi MD PA with current accurate billing information at the time of check-in and notify of any changes in this information.
- I understand that it is my responsibility to know my office co-pay and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the office also has contractual agreement with my health plan to collect co-pays at the time of services, and they are required to report to the carrier any enrollees falling to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that pay with cash , a money order, cashier's check, or credit card.
- I understand that there is a $25 fee to complete each paperwork (such as FMLA, Disability Handicap Parking Permit, School Physical) brought in by you and be completed by the office. Copy of vaccination record fee $10.
- I understand that the office will verify insurance eligibility, deductible amount, and co-insurance amounts prior to my office visit that I may have. I further understand that it is the policy to collect the deductible and/or co-insurance prior to my office visit. I further understand that the FEE I AM QUOTED IS AN ESTIMATE based on anticipated care in the office for the day.
- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice," and may be sent to an outside collection service if interest or legal expenses associated with the collection effort.
- I understand that the office will obtain the necessary authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand the office may also take verbal request to use my listed credit card for payment on my account or it may also use the same listed credit card on my account should my account be delinquent, or to cover an NSF check.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ THESE BILLING POLICIES AND MY FINANCIAL OBLIGATION AS PERTAIN TO THE PHYSICIAN CAROL N ABALIHI MD PA

Signature: _____

Relationship to Patient: _____

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ASSIGNMENT OF BENEFITS

Patients Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I request that payment of authorized Medicare/ other insurance company benefits be made on my behalf to Carol N Abalihi MD PA for any services furnished to me by that party who accepts assignments. I authorize any holder of medical or other information or its intermediary's carrier or any other insurance company claim. If item 9 of HCFA-1500 claim forms is completed, my signature authorizes releasing supplier agrees to accept the charge determination, and none covered services.

Co-insurance and deductible are based upon the charge determination by Medicare/other insurance company. In the event it is necessary to refer this account to a collection agency or attorney fees. If more than one individual executes this agreement, their liability shall be joint and several. All questions about fees should be asked prior to services being rendered. The person responsible for payment, please sign below having read and understanding all the above regarding information.
I am responsible for balance of my bill, after my insurance has responded. In the event I do not have insurance or my insurance is not valid, I am responsible for the balance of my bills entirely. I HAVE RECEIVED/READ A COPY OF THIS PRIVACY POLICY.

SIGN: _____ DATE: _____

IF SOMEONE OTHER THAN THE BENEFECIARY IS SIGNING THIS FORM, PLEASE COMPLETE THE FOLLOWING FOR THE PERSON SIGNING THIS FORM.

RELATIONSHIP TO BENEFICIARY: _____ PHONE: _____
STREET ADDRESS OF THE PERSON SIGNING THIS FORM: _____
CITY: _____ STATE: _____ ZIP: _____

REASON WHY BENEFICIARY CANNOT SIGN THIS FORM: _____ BY SIGNING ON BEHALF OF THE PATIENT, I ACKNOWLEDGE THAT I HAVE AUTHORITY TO DO SO.

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

This consent was signed by: _____ **(PRINT NAMEPLEASE)**

Signature: _____ **Date**_____

Witness: _____ **Date:** _____

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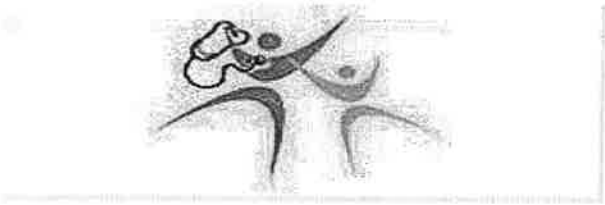
APPOINTMENT

If you are unable to keep appointment, contact us our office as soon as possible. All NO SHOW and Cancellations made with less than 24 Hours Notice will be subject to a $25 charge added to your next appointment.

Signature:_____

Date:_____



Carol N Abalihi MD PA

We'd Like your feedback

Name _____ DOB _____

I would like to receive communication by email Y/N

Email address _____

I would like to receive communication by telephone Y/N

Phone Number _____

I would like to receive communication by Text Message Y/N

Mobile Number _____

No thank you I do not wish to receive communication by post _____ (initial)

Signature _____ Date _____

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BILLING PURPOSES ONLY

NAME OF PATIENT: _____ DATE: _____

NAME ON CREDIT CARD: _____ DATE: _____

CREDIT CARD NUMBER: _____ DATE: _____

TYPE OF CREDIT CARD: _____ DATE: _____

VALID DATE: _____ DATE: _____

EXPIRATION DATE: _____

SECURITY CODE: _____

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Fax: 915-533-8055

Advance Directive Notification

Print Name: _____

Signature: _____

☐ I have a health care power of Attorney

☐ I have an Advance Directive

I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

Name: _____

Phone Number: _____