ATA AHMAD MD & ASSOCIATES
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 _____

Referring Physician _____

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 MD & Associates 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 _____

ATA AHMAD MD & ASSOCIATES

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: _____

Please list Current Medications:
_____
_____

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		
Father		
Grandmother		
Grandfather		
Siblings		

Vaccines:
FLU VACCINE _____ COVID19 VACCINE: _____
Date Given _____ Dates Given _____
PNEUMOCOCCAL VACCINE _____

For patients 65 or older:

I have fallen in the past year. ○ YES ○ NO

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

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 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 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 $35.00 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. There will be a $30.00 handling fee for NSF returned checks.

8. Your medical information cannot be disclosed to HIPAA regulations unless you authorize this office to do so in writing. If you wish to have your spouse, partner, or signification other 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 expect for me.

9. I understand that Dr. Ahmad & Associates 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. 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 cod 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, Dr. Ahmad & Associates require 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.

13. I authorize Dr. Ahmad & Associates 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

Consent to Obtain Prescription History
Ata Ahmad, MD FACS / Ronak Pate, DO
11740 FM 1960 RD WEST, HOUSTON, TX 77065
281-970-8484
Consent to Obtain Prescription History

***Please read and check both boxes as acknowledgement to terms of this form.

□ Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medications list in your medical chart and decrease adverse drug reactions or inaccurate medication information such as names or dosages. By signing this consent form, you agree that Ata Ahmad, MD PA can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes. Understanding all the above, I hereby provide informed consent to Ata Ahmad, MD PA to request, view and use my external prescription history for treatment purposes. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

☐ By entering in my demographic information below, I hereby give Ata Ahmad MD, PA my consent to request, view, and use my external prescription history for treatment purposes.

Name: _____

Date of Birth: _____

Today's Date: _____

First Point of Contact Screening

Name: _____ Date: _____

We are committed to providing a safe environment for our patients. If you answer "Yes" to any of the questions, please help us prevent the spread of germs by wearing a mask and performing hand hygiene.

Do you have any of the following contagious symptoms?

- Fever
- Cough
- Sneezing or Runny nose
- Body Aches (other than from an injury)
- Night Sweats
- Severe Headaches
- Stiff Neck
- New rashes or open sores on your skin or in your mouth
- Eye redness, swelling or discharge
- Unexplained bleeding
- Vomiting or Diarrhea

In the last past 3 weeks, have you traveled outside of the U.S.?

If yes, where - _____

In the past 3 weeks, have had close contact with someone who has traveled outside of the U.S.:

If yes, where - _____

Have you been in close contact with a person confirmed to have coronavirus? _____

Office Staff Reviewer: _____

Check all Actions taken:

☐ No Action
☐ Mask applied and cough/handwashing etiquette provided
☐ Patient isolated from others (moved to room or separated from others)
☐ Clinical lead notified

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

a. I may revoke my right at any time by contacting ATA AHMAD MD PA at 281-970—8484.

- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
- I understand that my insurance carrier will have access to my medical records for quality review/audit.
- I understand that will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
- I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- I understand that this document will become a part of my medical record.

By signing this form, I attest that (1) have personally read this form (or had It explained to me) and fully understand and agree to Its contents. (2) have had my questions answered to my satisfaction, and the risks, benefits. and alternatives to telemedicine visits shared with me in a language I understand; and (3) am in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name

Patient/Parent/Guardian Signature

Witness Signature

Date

The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation
For its support of this document through funds awarded by the Physicians Foundation.

ATA AHMAD, M.D. / RONAK PATEL, D.O.
GENERAL SURGEONS
Phone No. (281) 970-8484 Fax No. (281) 970-8485

AUTHORIZATION FOR RELEASE OF PROTECTED RECORDS

I AUTHORIZE **Ata Ahmad and Associates, 11740 FM 1960 Road West, Houston, Texas 77065** to:

☐ **release** ☐ **receive**

PATIENT'S NAME: _____ **DOB:** _____
SOCIAL SECURITY: _____ **DATE OF SERVICE:** _____

INFROMATION TO BE RELEASED:

☐ Face Sheet	☐ Operative Report	☐ Emergency Report
☐ Discharge Notes	☐ Pathology Report	☐ Clinic Notes
☐ History and Physical	☐ X-Ray Report	☐ Autopsy Reports
☐ Progress Report	☐ Lab Reports	☐ Complete Report
☐ Consultations	☐ Discharge Summary	☐ 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, e.g., 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 INFROMATION: 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 AUTORIZATION TO RELEASE INFORATION

_____ _____
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#

Dr. Ata Ahmad & Associates

OFFICE POLICY

AUTHORIZATION TO TREAT:

I hereby grant permission to the authorities of Dr. Ata Ahmad & Associates 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, Dr. Ata Ahmad & Associates, 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 Dr. Ata Ahmad & Associates 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
Dr. 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: _____

Dr. Ata Ahmad & Associates

FINANCIAL POLICY

FINANCIAL POLICY:

I have read and understand the Patient Financial policies, procedures, and authorizations of Dr. Ata Ahmad & Associates, 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 ATAA is true and correct to the best of my knowledge and that I am responsible for keeping it updated. I promise to pay to ATAA all charges and expenses for services provided to me by ATAA 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 ATAA. 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 Dr. Ata Ahmad & Associates within three (3) days of receipt. I will endorse the check; Write Payable to "Dr. Ata Ahmad & Associates" and "For deposit only" under it. Send all correspondence to: Billing Manager, Dr. Ata Ahmad & Associates, 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: _____

Dr. Ata Ahmad & Associates

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 Dr. Ata Ahmad & Associates 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 Dr. Ata Ahmad & Associates 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: _____

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

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party 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: _____

Acknowledgement of Surgical Assistant

Please be informed that a "Licensed/Certified Surgical Assistant" or a Physician Assistant "PA-C" (also, both known as "Licensed/Certified Surgical Assistant") 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 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 however is determined solely by the primary surgeon and deemed necessary for safe outcomes.

Usually, Licensed/Certified Surgical Assistants and Physician Assistants will bill the patient's insurance company for services rendered. In the case of denied payment by the insurance company, the patient will receive a bill from the Licensed/Certified Surgical Assistant or Physician Assistant. The maximum amount you will be billed is $750.00.

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 assistant surgeons as "Out-of-Network Providers" or will not contract with Licensed Surgical Assistant & Physician Assistant-PA-C. 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 billing office at 832-655-4141 to speak to a billing specialist or email us at Lin.Mi@uspcorporate.com.

I have read and acknowledge the above information.

Patient signature: _____ Date: _____

Printed name: _____ Date of Birth: _____ Surgery Date: _____

Witness/MD Office: _____ Surgeons Name: _____