A-Z PRIMARY CARE AND WALK-IN CLINIC

2940 FM 2920 Suite 150|Spring, Texas 77388 | 281-801-4286

Noureen Zohra, MD
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All questions contained in this questionnaire are strictly confidential & will become part of your medical record.

Name: ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Phone #: **Alternate Phone #:**

Email:

Physical Address:

Mailing Address:

Emergency contact name: **Phone #**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Pharmacy Name: **Phone #:**

POLICIES

Thank You for choosing A-Z Primary Care and Walk In as your healthcare provider. We are committed to taking care of every aspect of your health. Your clear understanding of our policies is important to our professional relationship. We ask that you carefully read and initial each statement, then please sign at the bottom.
We require a copy of all insurance cards and ask that you present those at each visit along with your driver's license or photo ID.

INSURANCE: _____
The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment. If you have an HMO policy, YOU MUST change your PCP to one of our providers before your visit. We will gladly file your insurance claims on your behalf. We will not become involved in disputes between you and your insurance regarding coverage and/or policy benefits. **PAYMENT IS DUE AT TIME OF SERVICE. Any balances on your account are due prior to being seen by our providers.**

RETURNED CHECKS: ____
There will be a $35 service fee on all dishonored checks. If payment is not received with full amount of check plus service fee within 10 days your information will be filed with The Harris County Hot Check Division. If you have any occurrences, we will no longer be able to accept checks from you.

PRESCRIPTIONS: _____
Refills: It is the patient's responsibility to contact their pharmacy 5 days prior to running out of medications. Refills may take 3-4 days to be refilled. Please do not leave multiple messages for this may slow down the process.
Medications will only be done during business hours and not through our answering service.

MEDICAL RECORDS: _____
There is a $25 fee for the first 20 pages of any medical record and must be paid prior to release. A signed medical records release form must be signed, and 72 hr. advance request is required. For any forms that need to be filled out and signed by a physician a $25 fee must be paid in advance and a 72-hr. advance notice is required. This includes FMLA, disability, medical supplies, or any formal document needing a physician letter.

MINORS: _________
All patients under the age of 18 years of age, will need to be accompanied by a parent or legal guardian. Parent or legal guardian must be present through the entire duration of the appointment. If a parent or legal guardian is unavailable to accompany the patient, then a MEDICAL TREATMENT AUTHORIZATION form must be completed giving another adult permission to accompany the patient

Please list the individuals who we are allowed to discuss medical information with:

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Do you consent to a medical exam and any procedures/test deemed necessary by our providers while you are in our office? **YES/ NO**

Do you consent A-Z Primary Care and Walk In to leave test result information on your voicemail? **YES /NO**

Do you consent our office to release medical information to any specialist that we refer you to or currently being treated by? **YES/NO**

I have read, understand, & agree with all policies & procedures of A-Z Primary Care & Walk-In Clinic

Print name: ________________________ **Signature:** ____________________________ **Date:** _____________________

Consent for Medical Care

Authorization for examination and treatment: I authorize the examination and /or treatment considered necessary for the above name patient, and the treatments and procedures will be performed by physicians, and or assistants / nurse practitioners of A-Z Primary Care and Walk In. Authorization is hereby granted for such treatments, procedure, administrations of local anesthetics, medications, or other treatments as deemed reasonable and medically necessary for care.

Assignment of Benefits

Insurance Benefits: I authorize A-Z Primary Care and Walk In to furnish to my insurance company to process my claim, including release of medical records as necessary. I understand that my insurance coverage is a contract between myself and the insurance, and I acknowledge that co-payment, deductible, and co-insurance amounts are due at the time of service as stated in my health insurance agreement. I hereby authorize and instruct my insurance carrier to make payments directly to A-Z Primary Care and Walk In, for medical expenses benefits.

Notice of Non- Coverage: I understand that in the event of non-coverage, I am responsible for payment, at the time of service to A-Z Primary Care and Walk In for any service or item provided during treatment. Non-coverage would include uninsured patients, failure to provide proof of insurance coverage, or any services or items not covered by your insurance.

Patient Privacy and Rights

Notice of Privacy Practices: I acknowledge that I have been made aware and offered a copy of the A-Z Primary Care and Walk In notice of privacy practices. Privacy Policies related to the handling of patient's private health information.

Patient Rights: I understand that I have the right to participate in my plan of care and treatment. I have the rights to refuse treatment and be informed of the consequences of such refusal.

Patient/Guarantor Signature ____

Date ____

Relationship to Patient ____