Khalid Shafiq, MD,
FACC, FSCAI
Board Certified:
Internal Medicine
Cardiovascular Diseases
Interventional Cardiology

Paris Cardiology Center

Diagnostic, Interventional & Nuclear Cardiology and Peripheral Vascular Intervention

PATIENT INFORMATION EACH VISIT

REFERRING PHYSICIAN _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE # _____

EMAIL: _____

PRIMARY INSURANCE: _____

2NDARY INSURANCE: _____

3RD INSURANCE: _____

Nursing Home/Home Health/Hospice/Skilled Bed _____

CELL:# _____ EMERGENCY NUMBER:# _____

EMERGENCY CONTACT: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Declined to Specify ❑Hispanic or Latino ❑ Native Hawaiian or other Pacific Islander ❑ White

Ethnicity: ❑ Declined to Specify ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown/Not reported

Preferred Language: ❑ English ❑ French ❑ German ❑ Haitan/Haitian Creole ❑ Hebrew ❑ Hindi ❑ Italian ❑ Japanese ❑ Korean ❑ Polish ❑ Portuguese ❑ Russian ❑ Somali ❑ Spanish/Castilian ❑Swahili ❑ Thai ❑ Urdu ❑ Vietnamese

_____ _____

Patient Signature Date

PATIENT IS RESPONSIBLE IF INCORRECT INFORMATION IS PROVIDED

Office (903) 739-2700
Toll Free (866) 871-2700
1775 FM 195
Paris, TX 75462
www.pariscardiologycenter.com
Fax (903) 784-1749

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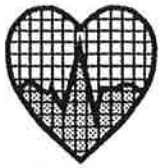

Paris Cardiology Center
Diagnostic, Interventional & Nuclear Cardiology
and Peripheral Vascular Intervention

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

The undersigned hereby authorizes _____ to release copies of certain medical record information as specified below.

Patient name: _____ Date: _____

Birthdate: _____ Social Security Number: _____ / _____ / _____

Address: _____

Dates of Treatment: _____

Your medical records and information will be released to Paris Cardiology Center and Dr. Khalid Shafiq, M.D.

Portion of the medical record to be released:

_____ History and Physical	_____ Discharge Summary	_____ Operative Reports
_____ Laboratory Reports	_____ Progress Notes	_____ X-Ray Reports
_____ Pathology Reports	_____ Orders	_____ Invasive Studies
_____ Non invasive studies	_____ Other	

The purpose or need for this disclosure is: _____

Please be advised that this consent will expire six months after the date of signature. I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance to it. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release Khalid Shafiq, M.D., agents and employees, from any liability in connection with the release of the information contained therein.

_____ _____
DATE PATIENT SIGNATURE

_____ (WITNESS)

Complete the following if the patient is a minor or unable to sign:

_____ _____
REASON UNABLE TO SIGN SIGNATURE OF PARENT/GUARDIAN/SPECIFY

NOTICE TO RECIPIENT OF COPIES OF MEDICAL RECORDS: PROHIBITION ON REDISCLOSURE: This information has been disclosed to you form records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $5000 in the case of each subsequent offence. 8700-510

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
Cardiovascular Disease and Interventional Cardiology

Elda Francis RN, MSN, FNP-BC

Dear New Patient:

Thank you for choosing Paris Cardiology Center as your cardiac care provider! We look forward to providing care for you and your family.

Enclosed you will find:

1. **Demographic form:** name, address, insurance information, referral, pharmacy, no show policy, etc. Please fill out to the best of your knowledge.

2. **Health History form:** knowing as much as possible about your Health History will help us tailor your health care to be as comprehensive as possible.

3. **Release of Records form:** if you have records from a previous primary care provider that may have relevance, prior medical records, or if you would like a future copy of your records from Paris Cardiology Center for yourself, please fill out this form. Also, please bring any relevant medical records and current medications in original bottles to your first appointment.

4. **Financial Policy Statement:** a summary of Paris Cardiology Center's policies. Please be sure to read policies and sign at the bottom.

5. **Privacy Policy:** a summary of Paris Cardiology Center's privacy policy, including your rights regarding your Protected Health Information (PHI) and our responsibilities in safeguarding your information.

Please fill out these forms and bring them with you to your first appointment (to insure we have the information ready for their appointment, please arrive 15-20 minutes early).

Please feel free to call (903) 739-2700 or Toll Free (866) 871-2700 with any questions, and we look forward to being your cardiac care partner in the years to come!

1775 FM 195
Paris, TX 75462
www.pariscardiologycenter.com

Office (903) 739-2700
Toll Free (866) 871-2700
Fax (903) 784-1749
After Hours (903) 785-4521

This package helps Dr. Shafiq and his staff to prepare for your New Patient appointment.

We have to put this information into the system before the doctor sees you.

You can mail it to us or bring it at the time of your Office Visit.

If this package is not filled out completely upon your arrival time, we will have to reschedule your appointment. It may delay your appointment further.

Thank you for your cooperation.

Front Desk
Paris Cardiology Center
Dr. Khalid Shafiq, MD

Enclosed you will find forms that will need to be filled out before you come for your initial appointment at Paris Cardiology Center. In addition to these forms you will need to bring:

1. Driver's license or ID

2. Insurance card

3. Your current medications or a list including name of medication, strength and dosage instructions.

Please call us with any questions you may have and we look forward to seeing you soon.

Thank you

Front Desk
Paris Cardiology Center
Dr. Khalid Shafiq, MD

Patient Information Each Visit

NAME: _____ ADDRESS: _____

PHONE #: _____ Email: _____

PRIMARY INS: _____ 2NDARY INS: _____

3RD INS: _____ Skilled Nursing Facility/Home Health/Hospice:

PHONE #: _____ _____

_____ _____

Patient Signature Date

PATIENT IS RESPONSIBLE IF INCORRECT INFORMATION IS PROVIDED!

Consent for Policies and Procedures at Paris Cardiology Center and Paris Cardiology Center Cath Lab.
Please initial.

- _____**Cancellation and no show policy:** PCC and PCCCL cordially requests that any cancellations should be notified to us within 24 hours. This allows us to refill your time slot with another patient who needs care. Cancellations and no shows will become part of your medical records. More than 2 cancellations can result in discharge from our practice and care and we will owe no further responsibility for your care. No show appointments will be charged a rate of $25.00.
- _____**Reschedule Policy:** Should you need to reschedule the appointment, please contact the office at 903-739-2700 to do so. Please note, our physician and NP schedule is often booked out 4 to 6 weeks so changing your appointment today may result in extending the wait beyond that 4 to 6 weeks.
- _____**New Patient Status:** If we have not seen you in 2 years. You will be treated as a new patient. Moreover, if you are a new patient at our facility, remember to complete any paperwork that may have been mailed to you. We cannot see you unless we have received your new patient paperwork and your records from PCP or requested specialists before your appointment date. You can call our office at 903-739-2700 Ext: 18 (Medical Records Department) to confirm we have received all information concerning your health prior to your visit with our physician and NP.

- _____**Charge for FMLA, STD (Short term disability) LTD (long term disability):** There will be a $15.00 charge for all such paperwork services.

- _____**Pre-Operative Appointments**: If you are being seen for a pre-operative appointment for a scheduled surgery at Paris Cardiology Center Cath Lab; please remember to keep any other appointments that have been scheduled for you at our practice.

- _____**Your first visit:** In order to make sure the physician has all the required information to treat you. Your first visit will be scheduled with our NP to collect all necessary information for your care and coordinate your treatment of care with Dr. Shafiq prior to your next visit.

REFERRAL INFORMATION

How did you first hear of us?

- ☐ Internet search (google)
- ☐ Internet advertisement
- ☐ Facebook
- ☐ Insurance
- ☐ Physician
- ☐ North American Spine
- ☐ Magazine - which one? _____
- ☐ Direct Mailing
- ☐ TV
- ☐ Billboard
- ☐ Radio
- ☐ Other _____

REFERRING PHYSICIAN

Name of Physician who referred you to us: _____ What city is their office in: _____

Name of your Primary Care Physician (PCP): _____ What city is their office in: _____

CONSENT FOR TREATMENT FORM

I understand that I have presented myself to Paris Cardiology Center/ Paris Cardiology Center Cath Lab for evaluation and/or treatment for my condition. I authorize and direct Paris Cardiology Center/ Paris Cardiology Center Cath Lab to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleague.

_____ (Initial)

FACSIMILE AUTHORIZATION FORM

I, the undersigned, authorize Paris Cardiology Center/ Paris Cardiology Center Cath Lab to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving Paris Cardiology Center/ Paris Cardiology Center Cath Lab five (5) days written notice. **This revocation may be by facsimile transmission, however, a written copy of the revocation must be mailed to Paris Cardiology Center/ Paris Cardiology Center Cath Lab as well.**

_____ (Initial)

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Paris Cardiology Center/ Paris Cardiology Center Cath Lab and any assisting physicians, PA, NP, RNFA, or CRNA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ (Initial)

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

I, the undersigned, acknowledge that Paris Cardiology Center/ Paris Cardiology Center Cath Lab at any given time may be a consultant, owner, manager, director, or developer of various entities including but not limited to companies that develop, distribute, and/or manufacture spinal biologics and implants and may have financial interests in various physician owned entities including but not limited to: medical device distributorships/manufacturers, management companies, laboratories, pharmacies, neuromonitoring, imaging, first assist and/or anesthesia companies, ambulatory surgery centers and/or hospitals, that may pertain to your care.

_____ (Initial)

ACKNOWLEDGEMENT FORM

I have received and/or reviewed the Notice of Privacy Practices. I have received a copy of the financial policy for this practice and agree to adhere to the terms.

_____ (Initial)

This release will remain in effect until revoked by me in writing.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Patient Name_____ Date of Birth ____/____/_____ Today's Date ____/____/_____

CONTACT AUTHORIZATION

Check where you can be reached during business hours ☐ Home ☐ Work ☐ Mobile

May we contact you at home? ☐ Yes ☐ No
Leave message with _____

Voicemail / Answering Machine ☐ Yes ☐ No

Mobile Phone ☐ Yes ☐ No

Family Member ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No
Leave message with _____

Voicemail / Answering Machine ☐ Yes ☐ No

Mobile Phone ☐ Yes ☐ No

Co-worker ☐ Yes ☐ No

I hereby give permission to Paris Cardiology Center/ Paris Cardiology Center Cath Lab to disclose and discuss any information related to my medical conditions to/with the following (relatives, or close personal friends).

Name _____ Relationship _____

Name _____ Relationship _____

OR

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions.

LEGAL GUARDIAN/ MEDICAL POWER OF ATTORNEY

Name _____ Relation _____ Phone # _____

Address _____

Patient Signature _____ Date _____

A copy of ANY Power Of Attorney, full or medical, will be furnished to this office within 14 days of this appointment with a copy of the POA holder's identification card to be kept on file in your chart. Failure to do so will result in our office being unable to supply any information to your POA holder.

PREFERRED PHARMACY

Name: _____ City: _____ Phone Number: ( ) _____-_____

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
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Cardiovascular Disease and Interventional Cardiology

DEMOGRAPHIC FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to Specify ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ☐ None ☐ Declined to Specity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Preferred Language: ☐ English ☐ French ☐ German ☐ Haitian; Haitian Creole ☐ Hebrew ☐ Hindi ☐ Italian ☐ Japanese ☐ Korean ☐ Polish ☐ Portuguese ☐ Russian ☐ Somali ☐ Spanish i Castilian ☐ Swahili ☐ Thai ☐ Urdu ☐ Vietnamese

Mailing address:	City:	State and zip code:

Social Security No:	Email address:	Home phone:	Cell phone:

Occupation:	Employer:	Employer phone no:

Referred to clinic by (please check one box:) ☐ Dr. ☐ Insurance plan ☐ Internet ☐ Family ☐ Friend ☐ Close to home/work ☐ Flyer ☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer	Employer address:	Employer phone no: ( )

PRIMARY INSURANCE:

Subcriber's name (if different)	Subscriber's S.S. no:	Birth date:	ID#	Group #	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE (if applicable):	Subscriber's name and birth date:	ID#	Group#:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

APPOINTMENT CANCELLATION AND BILLING POLICY

We realize that emergencies occur, however in order to help us be available to patients who would like to be seen we request that you notify us within a minimum of 24-hours if you need to cancel or reschedule an appointment. A $25 "NO SHOW" FEE MAY APPLY. As a courtesy to our patients, we will bill your insurance for you. Keep in mind that even though your insurance will be billed you are ultimately responsible for your bill.

The above information is true to the best of my knowledge. I authorize Paris Cardiology Center to treat me. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paris Cardiology Center to release any information required to process my claims.

Patient/Guardian signature:	Date:

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Paris Cardiology Center

Diagnostic, Interventional & Nuclear Cardiology and Peripheral Vascular Intervention

Patient

Nane_____DOB_____

Dear New Patients

Welcome to our practice!

VERY IMPORTANT PLEASE READ

In order to better serve you in the future, we need to know your past cardiac history. Please provide the following information:

Have you ever been treated by another cardiologist or heart surgeon? **YES** _____ **NO**_____

Name of cardiologist _____phone_____

Name of Surgeon _____phone_____

Facility name _____Address_____

Have you had previous testing done on your Heart, Arteries or Veins? If so, what doctor or facility did the testing? _____

Address _____phone_____

Have you had heart testing: (please circle)

Stress Test, Echo or Sonogram, CT scan, EP Study, Ablation on Legs, Holter Monitor, Carotid sonogram, Venous Mapping

Have you has heart procedures: (please circle)

Heart Cath, Heart Stents, CABG bypass, Heart valve, Pacemaker, Defibrillator, Stent to legs, Stent to carotid, Stent to Subclavian, stent to Kidney artery

If you answered yes to any of these questions we need you to sign the attached release, return it to our office ASAP so we can obtain the records before you come for your first appointment. If we do not receive your records prior to your appointment you will be rescheduled until after they are received

Health History Form

Today's Date: ____/____/____ **DOB:** ____/____/____ **Ht:** _____ **Wt:** _____**lbs**

Name: (Last) _____ **(First)**_____ **(MI)**_____ **Age:**_____

Referring Physician: _____ **Onset of Symptoms:** _____

Reason for Visit: _____

Past Medical History (Circle all that apply):

- ☐ Glaucoma or cataracts
- ☐ Carotid artery blockage
- ☐ Sleep apnea
- ☐ Asthma
- ☐ COPD
- ☐ History of smoking
- ☐ GERD (Reflux)
- ☐ History of gastric ulcers
- ☐ IBS/Crohn's
- ☐ Hepatitis B or C
- ☐ Diabetes (insulin or non-insulin dependent)
- ☐ Anemia (iron, B12)
- ☐ Hypothyroidism
- ☐ Hormone Replacement Therapy
- ☐ Emotional Disorders:
  - __ Depression
  - __ Bipolar
  - __Schizophrenia
- ☐ Dementia
  - __ Alzheimer's
  - __ Lewy Body
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ BPH (Benign Prostatic Hypertrophy)
- ☐ Kidney insufficiency/failure
- ☐ Dialysis
- ☐ Cancer (where)_____
- ☐ Edema (swelling)
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart stent/balloon
- ☐ Heart murmur
- ☐ Leaky heart valve
- ☐ Heart valve replacement
- ☐ Coumadin or other anti-coagulation therapy
- ☐ CHF (congestive heart failure
- ☐ Pacemaker: Date _____
- ☐ Defibrillator: Date _____
- ☐ Aortic aneurysm
- ☐ DVT, Pulmonary emboli
- ☐ Stroke (CVA)
- ☐ TIA (mini stroke)
- ☐ Atrial Fibrillation
- ☐ PAD (peripheral arterial disease)
- ☐ Varicose veins

Past Surgical History:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Risk Factors:

Type of Tobacco _____ amount _____p er day/week x _____years

Alcohol Use _____ per day/week/month x _____ years

Recreational Drug use _____ per day/week/month x _____ years

Immediate family history of heart disease: (mother/father/siblings)

_____

PERSONAL MEDICATION RECORD

Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	
Primary Physician Contact number:	

Allergic To / Describe Reaction	Allergic To / Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin)

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use Medical abbreviations.)	DATE STOPPED	Notes; Reason for taking / Doctor Name

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
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RELEASE OF RECORDS FORM

New Patient Consent to the Use and Disdosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Khalid Shafiq, M.D., PA., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the many health professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent,
* The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Khalid Shaliq, M.D., P.A., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take 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 Section164.506 of the Code of Federal Regulations.

I further understand that Khalid Shafiq. M.D., P.A., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Khalid Shafiq, M.D., PA.. change their notice, they will send a copy of any revised notice to the address provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.l fully understand and accept / decline the terms of this consent.

_____	_____	_____
Patient s Signature	Patient s Name (print)	Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Family members we may share your info with (if nobody, please write NONE and sign it):

_____ _____

_____ _____

_____

Patient's name (print)

_____ _____

Patient signature Date

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

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FINANCIAL POLICY STATEMENT

In an effort to provide the best medical services, we have established the following policies.
Your signature below signifies your willingness and understanding to comply with our policies.

POLICY STATEMENT: **PAYMENT POLICY** _____ Initial

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification and may take your picture at your first office visit.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Hands On Medicine, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to **pay in full** at the time of your office visit. We provide reduced rates for cash paying patients.
- If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.
- We accept cash and credit or debit card payments. Except for balances sent in the mail. There is a $40.00 bounced check fee in addition to fees charged by your financial institution.
- Payment is due within 30 days of receiving your bill. If your balance is not paid in full within 90 days your account will be sent to collections.

- Hands On Medicine is happy to continue providing care while you pay off this balance provided all office visits and other charges acquired from this day forward are paid in full at the time of service.

POLICY STATEMENT: **PRESCRIPTION REFILL POLICY** _____ Initial

- Please allow **3-5 business days for all prescription refills**. Ask your pharmacy to fax a refill request to the clinic at (903) 739-2700 or Toll Free at (866) 871-2700 to speed up the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

POLICY STATEMENT: **RECORDS** _____ Initial

- We are happy to provide you a copy of your medical records gratis. However additional copies will require a charge in accordance with OAR 847-012-000.

POLICY STATEMENT: **CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION** _____ Initial

It is **your responsibility** to advise the clinic of any change in **insurance coverage**, or **changes in name, address, or telephone number.**

Signature: _____ Date: _____

POLICY STATEMENT: **24-HOUR CANCELLATION/NO-SHOW POLICY** _____ Initial

- Our clinic policy requires a **24-hour cancellation notice** for all appointments. Your appointment time is reserved for you. If you do not show or give the clinic less than 24-hour notice, you will receive a letter and a bill in the mail. If you repeatedly neglect this policy, you will be dismissed as a patient.
- If you cannot make it to your scheduled appointment, please call to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who needs to be seen on that day, and helps us find time for you when you need to be seen on short notice.
- On Clinic Test / Cath / Surgical procedures $80 on missed appointment visits.
- **This charge will not be paid by your insurance company**.

Policy Statement: Referral Policy _____ Initial

In benefits plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating his/her patients' health care. If it is necessary for the patient to see a specialist, other than for direct-access services or emergency care, the primary care physician must request a referral to the patient's visit to the specialist. The referral must be for covered benefits under the plan.

I have read and understand the Policy for Paris Cardiology Center.

Signature: _____ Date: _____

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through

* If you have out-of-network benefits, we will be happy to give you a receipt so you may file.
* You must pay any copayment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
* The remainder of your bill will be sent to your health plan for direct payment to our office.
* If your insurance carrier has not paid our claim within 120 days, we may expect payment from you.
* If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
* You will remain responsible for any services that are not covered by your insurance plan.
* Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.
* If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, a $25 service charge will be added to your balance due.
* Your health plan may refuse payment of a claim for some of the following reasons:
  1) This is pre-existing illness that is not covered by your plan
  2) You have not met your full calendar deductible
  3) The type of medical services required is not covered by your plan
  4) The health plan was not in effect at the time of service
  5) You have other insurance which must be filed first

Although, benefits maybe verified at the time of service, any payment collected may not reflect the full patient responsibility. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company, which will result in you paying more for your services.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care. We are pleased to welcome you to our practice.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

Patient Signature _____ Date _____

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
Cardiovascular Disease and Interventional Cardiology

Please read and sign:

FOR EVERY OFFICE VISIT:

CO-PAYS Are Due In Full.
CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.
MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount.
MEDICARE W-SUPPLEMENT Insurance Will Be filed w-Any Balance Billed to Pat,ent.
INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.
NO INSURANCE: Total Visit Amount Is Due In Full.

FOR EVERY OFFICE PROCEDURE AND SURGERY:
CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.
MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount,.
MEDICARE W-SUPPLEMENT Insurance Will Be Filed w-Any Balance Billed to Patient.
INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.

NO INSURANCE: Total Visit Amount Is Due In Full Unless Other Prior Arrangements Have Been Made.
Please Ask Receptionist.

PROCEDURE SCHEDULED:
PROCEDURE DEPOSIT Is Due 1 Week Prior To Procedure Date.
PROCEDURE DEPOSIT AMOUNT Is Based On The Estimated Patient Balance Owed.

If you want to set up "Payment Plan" with our office, you should do so on your visit to the doctor. Any amount due after your insurance has paid will be billed to you. After fifteen days when you receive your bill, and you have not paid, you will be sent a collection letter from our office. Please make a payment within the following week or contact our office to settle your account thru a payment plan. You must pay off account in three installments or you can settle your account in one installment and receive a discount.
If we do not hear from you, your account will be turned over to an outside "Collection agency".

ANY BALANCES REMAINING after the above amounts are collected will be billed to the patient.
I have read the above policy and agree to payment as stated.

_____ _____

Patient or Responsible Party Date

Your signature below indicates you understand that if you receive covered services and/or diagnostic test from Paris Cardiology Center and have an HMO insurance or other insurance that requires the "contracted" Primary Care Physician to provide a referral/ pre-authorization for services and has not presented Paris Cardiology Center with such documentation, you may be financially responsible for such services.

If you have received prior approval from your primary care physician, you should contact his or her office and request that he/she forward a copy of the referral/authorization to this office immediately. They may fax this information to 903-491-9031. Services otherwise, may be subject to rescheduling.

_____ _____

Patient or Responsible Party Date