SALMA MAZHAR MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

PATIENT REGISTRATION INFORMATION

Name: _____ Sex: M ☐ F ☐
First *Middle* *Last Name*

Birth date: _____ Soc.Sec # _____-_____-_____ Driver License # _____

Address: _____ City/State/Zip: _____

Home Telephone :( )_____ Cell phone ( ) _____Email: _____

Marital Status: _____ Referring Physician/Person: _____

Patient's Employer: _____

Occupation: _____ Work Phone: ( ) _____

Pharmacy Name: _____ Pharmacy Phone: ( )_____

For appointment reminders or call back request or information regarding your health, OK to leave messages on answering machine? Yes ☐ No ☐

Is it OK to leave messages with family members? Yes ☐ No ☐

SPOUSE/PARENT INFORMATION

Name: _____ Birth date: _____

Soc.Sec #: _____-_____-_____ Sex: M ☐ F ☐

Cell phone: ( ) _____ Work Phone: ( ) _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Telephone: ( ) _____ Cell phone: ( ) _____

PRIMARY INSURANCE CARRIER

Company Name: _____ Group# _____

ID #_____ Member name: _____ Telephone: _____

SECONDARY INSURANCE CARRIER

Company Name: _____ Group# _____

ID #_____ Member name: _____ Telephone ( ) _____

I hereby grant permission to **Salma Mazhar MD. P.A.** to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary ,any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to **Salma Mazhar M.D P.A.**

_____ _____
Signature of Patient (Parent if Patient is minor) Date

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

PATIENT INFORMATION

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

****Please read and initial each paragraph****

____**Salma Mazhar MD PA** is committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

____ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Salma Mazhar MD PA** for any services furnished to me by any healthcare providers associated with this practice. I authorize any holder of medical information about me to release to the practice Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

____I appoint **Salma Mazhar MD PA** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

____ Unless I request to the contrary, in writing, I will receive appointment reminders on the answering system of any phone number I have provided on this registration form and/or via e-mail and/or appointment reminder cards sent by mail.

____ I acknowledge receipt of the **Salma Mazhar MD PA Policies and Informational Guide** which includes information on fees associated with no-shows, same-day cancellations and failed appointment as well as other subjects including: appointments, test results, telephone calls, refill requests, records requests, insurance, referrals, payment for services and emergencies.

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 ask questions.

We understand that your health coverage is provided through _____
(Insurance Company)

- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made.
- 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 45 days, we will 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 amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan
    2) You may not have met your full calendar year deductible
    3) The type of medical service 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

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitation in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

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 first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Salma Mazhar MD PA

I have completed this form with accurate information. I have read and understand my obligation and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered by my insurance carrier.

PRINT NAME_____ **DOB** _____

Signature of Patient or Authorized Representative **Date**

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Chief Complaint: (*Briefly describe your main reason for coming to the doctor today*)

_____

_____

Known Medical Problems: _____

_____

Childhood Illnesses: _____

Previous Surgeries: (*include dates*) : _____

_____

_____

Social History:

Do you smoke now? Y ☐ N ☐ How much _____ How long _____
Did you smoke in the past? Y ☐ N ☐ How much _____ Quit date _____
Do you drink alcoholic beverages? Y ☐ N ☐ How often _____
Do you do or did drugs? Y ☐ N ☐ What, when and route _____
Do you drink coffee/tea/sodas? Y ☐ N ☐ How much _____
Do you follow a particular diet? Y ☐ N ☐ If so what _____
Do you exercise regularly? Y ☐ N ☐ What kind _____ How much _____
What kind of work you do now? _____
What kind of work have you done before? _____
Are you aware of any hazardous exposures associated with your present or past employment? Y☐ N☐
If yes, what _____
What is the highest level of education you have had _____
Where were you born? _____ Where else you have lived? _____

Family History *(specify the problem).*

Father: _____ Mother: _____
Brothers/Sisters: _____
Others: _____
Allergies: _____ Reaction: _____
_____ _____
_____ _____
Current Medications taken: _____
_____
_____
_____

Screening Tests: (*List the date and place where done as applicable to you)*

Last Pap smear: _____ Last Mammo: _____
Last Colonoscopy: _____ Last PSA: _____
Last Bone density scan: _____

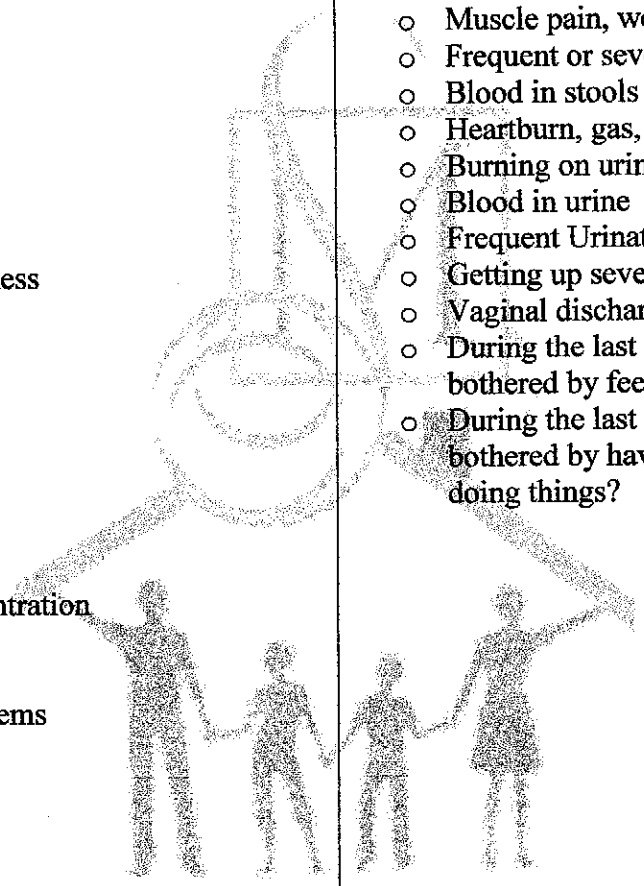
Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Review of Systems: (*Please check any of the problems below that you have now or have had recently).*

- o Fever
- o Sexual problems
- o Chills
- o Vaginal discharge/menstrual problems
- o Night sweats
- o Breast pain/lumps
- o Fatigue
- o Painful testicles
- o Trouble sleeping
- o Skin rash
- o Snoring
- o Itching
- o Excessive daytime sleepiness
- o Change in mole
- o Poor appetite
- o Desire psychiatric help
- o Excessive appetite
- o Work or family problem
- o Weight gain
- o Excessive worry, anxiety
- o Weight loss
- o Loss of memory or concentration
- o Eye problems
- o Numbness or tingling
- o Hearing trouble/Ear problems
- o Trembling, shaking
- o Sinus trouble
- o Dizziness
- o Gum problems
- o Blackout spells
- o Persistent hoarseness
- o Frequent cough
- o Coughing up blood
- o Difficulty breathing
- o Chest pain/tightness/pressure
- o Heart racing
- o Swelling of legs, feet or hands etc.
- o Difficulty swallowing
- o Nausea
- o Vomiting
- o Diarrhea



- o Breast pain/lump Constipation
- o Black stools
- o Take birth control pills
- o Take hormone replacement therapy
- o Joint pain, swelling, stiffness
- o Muscle pain, weakness
- o Frequent or severe headaches
- o Blood in stools
- o Heartburn, gas, belching, bloating
- o Burning on urination
- o Blood in urine
- o Frequent Urination
- o Getting up several times at night to urinate
- o Vaginal discharge? Menstrual problems
- o During the last month, have you often been bothered by feeling down, depressed, or hopeless?
- o During the last month, have you often been bothered by having little interest or pleasure in doing things?

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

Re: _____ _____
(Patient Name) (Date of Birth)

PATIENT PORTAL ACTIVATION

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, request medication refills, request referrals to specialists, view summaries of your recent visits and more. In order to activate this functionality for you personally, we **MUST** have an active e-mail address associated with your account.

Please list your e-mail address here:_____ @_____

We will activate your account today and you will receive and e-mail within 24-48 hours with your login information.

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize this office to have access to my prescription drug history. I understand this authorization allows this office to obtain my prescription history electronically from retail pharmacies.

_____ _____
Patient's Signature Date

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Federal privacy guidelines, HIPAA, prevent this office from disclosing protected health (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize Salma Mazhar MD PA to disclose PHI from my medical or financial record to the following person/people:

1. Name: _____

Relationship: _____

Type of Information: (Check One) ☐ Medical ☐ Financial ☐ Both

2. Name: _____

Relationship: _____

Type of Information: (Check One) ☐Medical ☐ Financial ☐ Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

_____ _____
Patient's Signature Date

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

DISCLOSURE OF CONTROLLED SUBSTANCES

Please answer below to comply with our office policy for the use of controlled substances.

1. Have you filled any controlled substance prescriptions by any other physician outside of this office? **Yes** ☐ **No** ☐ *(please check)*
2. If **YES** to the above question, please list the name of the prescription, the physician's name, and which pharmacy it was filled at.

3. For any patient on controlled substance, we will perform urine drug screen (UDS) at appointment visit. _____ *(Patient Initial)*
4. The office will verify your controlled substance prescriptions with Prescription Access in Texas through the Texas Department of Public Safety website, which is the prescription monitoring program. _____ (*Patient Initial*)
5. Urine or buccal swab is sent to outside laboratory for further testing and you will receive additional bill from them. _____ *(Patient Initial)*

Failure to comply and/or any falsified information will lead to denial of controlled substance prescriptions and might lead to termination from the office.

Prescriptions for controlled substances will vary upon provider evaluation.

_____
Patient Name (*printed*)

_____
Patient Signature

_____
Date

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

Policies and Informational Guide

Our mission is to provide excellence in medical care and personal service. We honor the doctor-patient relationship and encourage you to take an active role in your health.

Appointments
The office is open for appointments from 8:00am – 5:00pm, Monday through Friday & Sat 9:00 am – 12:00 PM; we are closed for most major holidays. Annual physicals and routine follow-up appointments are generally scheduled in advance. Same day appointments are also available. Walk-ins welcome for acute illness and urgent issues.

Proof of insurance is required at each appointment. Our check-in staff will also verify your demographic information at each visit with you.

Please bring your medications bottles to each appointment.

Remember to see the front desk staff to checkout before leaving the office. In order to honor all scheduled appointment times, we ask that you have a formal scheduled appointment for any service, including injection only appointments. Many times these services can be accommodated same day; we ask that you call in advance to make us aware you are coming. This is to ensure that we can provide the best possible service to all of our patients.

No-Show/Cancellation Policy, late show policy
As a patient in our clinic, it is your responsibility to keep scheduled appointments. The clinic requires that all appointment cancellations be received by 3:00pm on the prior business day (example, by 3:00pm on Friday for a Monday appointment). Failure to cancel the appointment before 3:00pm the business day prior to the scheduled appointment will result in the assessment of a failed appointment fee of **$25**. Any appointment scheduled and cancelled on the same day will also result in the **$25** failed appointment fee.
It is your responsibility to remember your appointment. We do not guarantee that reminder calls will be made in advance.

In order to continue to provide prompt attention to all of our scheduled patients, it is necessary to have a late arrival policy. The clinic will consider a **"failed appointment"** at any time a patient has not given the advance notice required above or has failed to arrive within 10 minutes of their appointment time. If a patient arrives 10 or more minutes late, they may be asked to reschedule or wait longer to be called back and the appointment will be considered a "late cancellation" and result in the assessment of a failed appointment fee.

Telephone Calls

Our telephone is answered 24 hours a day. After hours, a provider is always on call and available to handle urgent patient problems. Non-emergency calls, such as appointments, medications, refills and test results should be made between 8:00am and 5:00pm Monday-Friday.

Emergencies
If you have a true medical emergency, call 911 or go to the Emergency Center of the nearest hospital. Ask them to contact our office at (972) 216-5152

Test Results
It may take several days to a week to get laboratory and radiology tests results back to our office. When calling our office for test results, please ask for your provider's medical assistant who will let you know if the results are available. If they are unavailable at the time of your call, we will notify you when they are available. It is the normal process of our office to notify you of routine lab results or diagnostic tests by phone. If we are unable to reach you by phone, we will mail you a letter to notify you to call us for your results.

Salma Mazhar MD PA
1210 N. Galloway Ave.
Mesquite, TX 75149

Requests for Refills
Refills for medication, including those medications that have no remaining refills or requests for additional refills, should be called directly to your pharmacy. Your pharmacy will contact us for refill authorization, if necessary. All prescription refills requests are taken only during regular office hours and filled within 72 hours.
For controlled substances (also known as triplicate prescriptions), you must make an appointment in advance. (NO WALK-INS)

Referrals and Pre-Certifications
If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility, etc. it is your responsibility to inform the office of this requirement prior to referral.
Routine referrals and authorizations requests might take up to 10 business days to process. Urgent requests will be processed as soon as possible.
As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you.

Prescription prior authorizations
We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward the prior authorization form to our office.

Requests for Medical Records
In accordance with Texas laws, Salma Mazhar MD PA requires written requests for the release of medical records.The administrative fee associated with retrieving and copying medical records is based on current Texas laws and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records. Please allow 15 business days for records request to be processed.

Payment for Services
We recognize the need for a clear understanding between you and our office regarding payment for services. Charges for professional services and treatment depend upon your diagnosis and the terms of your insurance contract. Co-payment and unmet annual deductibles are payable at the time of your visit. We accept cash, check, Visa, and MasterCard. There is a $35 service charge for returned check.

Insurance
Please notify us immediately if there are any changes in your coverage, employer or insurance company. When a change occurs, we will verify the new coverage and do our best to ensure a smooth transition. Our front office staff is always available during regular office hours to answer any questions you may have.

Letter/ Form completion
At the discretion of the health care provider, letters and forms requiring medical review and physician signature are subject to a $25 fee plus $5 per page/side. This fee must be paid prior to the form being completed.

Talking to Your Doctor
You may not remember everything you want to ask your health care provider. You may find it helpful to write down questions prior to your appointment. When you do get answers to your questions, write them down, too. That way, when you go home, you won't forget and you will be better equipped to answer questions that your family may have. Keep track of how you are feeling and any changes you notice so you can inform your provider. By staying organized, you are helping yourself remain in control of your illness.

Dr. Salma Mazhar
901 N. Galloway Avenue, Suite 107
Mesquite, TX 75149
Phone (972) 216-5152

Patient Name: _____ **Contact Phone #:** _____

Patient DOB: _____ **Date:** _____

Chart Update

1. Do you experience any of the following symptoms? If so, you may have allergies. Please circle any symptoms you may experience and the severity.

a. **Stuffy Nose**	Mild	Moderate	Severe
b. **Runny Nose**	Mild	Moderate	Severe
c. **Itchy Nose**	Mild	Moderate	Severe
d. **Itchy Throat**	Mild	Moderate	Severe
e. **Itchy/Watery Eyes**	Mild	Moderate	Severe
f. **Sneezing**	Mild	Moderate	Severe
g. **Headaches/Migraines**	Mild	Moderate	Severe
h. **Dizziness**	Mild	Moderate	Severe
i. **Congestion**	Mild	Moderate	Severe
j. **Skin Rashes**	Mild	Moderate	Severe
k. **Post-Nasal Drip**	Mild	Moderate	Severe
l. **Sinus Infections**	Mild	Moderate	Severe
m. **Fatigue**	Mild	Moderate	Severe

In your medical past, have you required doctor's visits or treatment for the above symptoms?
Yes No

2. Overall, what is the severity of your allergy symptoms?
Mild Moderate Severe

3. When are your allergy symptoms present?
Rarely Seasonally Most of the year

4. How often do you take prescription or over-the-counter medications for your allergies?
Rarely Sometimes Frequently

5. Do you ever suffer from medication side effects such as dry mouth or drowsiness?
Rarely Sometimes Frequently

Medical History

1. Are you pregnant? If there is *any* possibility that you are pregnant, please notify your provider before you have the allergy test.	Yes	No
2. Have you been diagnosed with HIV?	Yes	No
3. Have you ever had a stroke?	Yes	No
4. Have you ever been diagnosed with or do you have a history of cardiovascular disease?	Yes	No
5a. Are you on any blood pressure medication(s)?	Yes	No
b. If yes, please state which medication(s): _____		
6a. Are you on any heart medication(s)?	Yes	No
b. If yes, please state which medication(s): _____		
7. Have you ever had a severe anaphylactic reaction *(severe allergic reaction)* that required emergency medical attention?	Yes	No
8. Do you have uncontrolled asthma?	Yes	No
9a. Within the past year have you had an allergy scratch test?	Yes	No
b. If so, did you have Immunotherapy Medication made for you?	Yes	No
10. Do you have a history of taking any allergy medications including allergy shots?	Yes	No

_____
Patient Signature

Office Use Only
Provider Notes: _____

_____

_____

_____ _____
Provider Signature **Date**