Hamid Burney, MD, PA

Phone: (817) 467-2266 Fax: (817) 467-8822

REGISTRATION FORM

Today's Date_______________ **Social Security Number:** ____________________________

Name: ______________________________ **Date of Birth:** ________________ **Sex:** ☐ **Male** ☐ **Female**

Address:______________________________**City:**_______________**State:**________**Zip**____________

Phone (_____) ______________ **Work Phone (_____)** ______________ **Cell Phone (_____)** ________________

Employer:______________________________ **Spouse or Parent's Name:**__________________________

Emergency Contact:____________________________ **Relation to Patient:**__________________________

Emergency Contact's Primary Phone (_____) __________________ **Alt. Phone (_____)** ________________

Email Address:______________________________ **Language:** ☐ **English** ☐ **Other**______________

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Unknown**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**
☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Other**

INSURANCE INFORMATION

Plan Type: ☐ **HMO** ☐ **PPO** ☐ **EPO** ☐ **POS** ☐ **Other:**______________________

Name of Insured____________________________**DOB**____________**Relationship to Patient** ______________

SSN#:__________________ **Name of Employer:**______________________ **Work Phone: (___)**____________

Address of Employer:____________________________**City**_______________**State:**_______**Zip** __________

Insurance Company____________________________ **Grp #**________________ **ID#**__________________

Ins Co Address:______________________________ **Ins Co. Phone:**____________________________

--------DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING----**

Plan Type: ☐ **HMO** ☐ **PPO** ☐ **EPO** ☐ **POS** ☐ **Other:**______________________

Name of Insured____________________________**DOB**____________**Relationship to Patient** ______________

SSN#:__________________ **Name of Employer:**______________________ **Work Phone: (___)**____________

Address of Employer:____________________________**City**_______________**State:**_______**Zip** __________

Insurance Company____________________________ **Grp #**________________ **ID#**__________________

Ins Co Address:______________________________ **Ins Co. Phone:**____________________________

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This offices' policy is to collect this co-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

____ ____________________

Printed Name of Patient Date of Birth

____ ____________________

Signature of Patient or Responsible Party (if minor Patient) Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed, or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

____
Patient's Name(PRINT) Date of Birth

____
Patient's Signature

____
Date

____
Signature of Patient Representative (If Applicable)

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I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care. I understand that any and all information can only be given in person, and after presenting a picture ID:

Name	Relationship

Patient Printed Name   Date of Birth

Patient Signature or Legal Representative

Date

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Phone: (817) 467-2266 Fax: (817) 467-8822

Main Office Location
3600 Matlock Road, #102
Phone: 817-467-2266 Fax: 817-467-8822

Authorization to Release Healthcare Information

This is a release form for authorization of your medical information to be transferred between health care providers, health insurance companies and any other party involved in your medical care.

Patient Name: ____**Date of Birth:** ________________________________

Social Security #: ____

I authorize the following facilities/hospitals and doctor(s) to release all medical information Hamid Burney, MD, PA to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, and any other healthcare information relating to my condition.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

*1*____

*2*____

*3*____

*4*____

*5*____

____ ____________________________

Patient Signature Date