diagnostic group
INTEGRATED HEALTHCARE SYSTEM
PHYSICIANS

PATIENT INFORMATION

*Patient Name:*_____ _____ _____
Last *First* *Middle Initial*

*Address:*_____ _____ _____
Street or P.O. Box *City, State* *Zip*

*Date of Birth:*_____/_____/_____ *Race:*_____ *Gender:* ☐ *Male* ☐ *Female* *Social Security #:*_____
Marital Status: ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* *Spouse's Name*_____
*Primary Phone #:*_____ _____ _____ *Email Address:* _____

*Primary Care Physician (PCP or Regular Doctor):*_____

*Employer:*_____ _____
Name *Address*

_____ _____
City, State, Zip *Phone Number*

*Nearest Relative:*_____ _____ _____
Last/First Name *Relationship* *Phone Number*
*Employer*_____
Primary Insurance _____ *Policy #* _____
*Name of Policy Holder*_____ *Group #* _____
*Policy Holder Date of Birth*_____
SS# of Policy Holder _____ *Relation to Policy Holder* _____

Workers Compensation:
Policy # _____
*Group#*_____

I hereby authorize Diagnostic Group to receive and release any medical or surgical information necessary for the treatment of my medical or surgical conditions in order to process any and all insurance claims on my behalf. I also sign to Diagnostic Group all medical and surgical benefits including major medical to which I am entitled.

I accept responsibility for any unpaid portions of these claims that my health plans do not cover and will make all payments to Diagnostic Group in a timely and conscientious manner. I further understand that it is the policy of Diagnostic Group to provide only appropriate treatment for the diagnosis and therefore, is entitled to appropriate payment for services provided. A $35 charge will occur for any missed visits or returned checks. There will also be a minimum charge of $35 for all requests for medical records other than those requested from other physicians for coordination of care.

I agree that any medical treatment is my financial responsibility. I understand that if I am enrolled in a managed care plan (i.e. HMO, POS), I must have a referral from my primary care physician to be seen by a specialist. All balances on my account that are 60 days overdue must be resolved before another appointment is scheduled. Outstanding balances not resolved within 90 days will be reported for collections and will go against my credit report.

I have been provided the opportunity to review HIPAA policies of this clinic. My acknowledgement of these polices will remain in effect until revoked by me in writing. A photocopy of this acknowledgement with my signature is to be considered valid as original.

_____ _____
Patient Signature or Guardian Signature (if appropriate) Date

Authorization for Release of Protected Health Information

Agreement and Consent

Diagnostic Group complies with HIPAA which dictates that our office must do everything possible to protect your medical information. For this reason, please indicate below the names of each family or friend who we can talk to and release your information to regarding appointments, prescriptions, test results, surgery dates and any other medical need we may have.

I will allow medical information and test results, abnormal results and appointment information released to the following people.

Name	Relationship	Phone Number

Please indicate the phone number where you can be reached or a message can be left for you during our routine business hours of Monday through Thursday, 8:00 am to 5:00 pm and Friday 8:00 am to 12:00 pm.

1. (_____) _____- _____ ☐ home ☐ cell ☐ other _____

2. (_____) _____- _____ ☐ home ☐ cell ☐ other _____

_____I authorize the release of my complete medical record. I understand I have the right to revoke this authorization in writing at any time by sending written notice of revocation to person(s) authorized in paragraph above to disclose the information.

_____ I *do not want any medical information or test results released to anyone but myself.*
(Initial)

I understand that Diagnostic Group is in compliance with HIPAA and has provided me the opportunity to review it in detail. My signature below verifies my understanding of my right. The decisions I have made on this form will be valid until revoked in writing by me.

_____ _____
Signature of Patient/Guardian (if appropriate) Date

_____
Name of Patient (Please Print)

Medical Records and Authorization for Use of Disclosure of Protected Health Information

I hereby authorize _____, M.D.

_____ _____
Address City, State, Zip

_____ to furnish all medical information to:
Phone Number

Diagnostic Group

_____
Physician's Name
3406 College Street
Beaumont, Texas 77701

The information may be used only for the purposes of medical treatment.

I fully understand that the information released may include information about drug or alcohol screens, HIV testing or diagnosis, and psychiatric or psychological testing or diagnosis.

Please print the following information:

Patient Name: _____

Address: _____

_____

Phone # _____

SSN: _____

Date of Birth: _____/_____/_____

_____ _____
Patient Signature Today's Date

Financial Policy

I, _____, understand that my insurance co-payment is due at the time of service. Diagnostic Group will file a claim with my medical insurance company for services rendered. I understand that after payment is received, there may be charges that are not paid and/or covered by my insurance plan. These include but are not limited to:

- Medical Insurance Deductible
- Co-Insurance or Out-of-Pocket amount
- Unauthorized Medical Visit
- Provider is Out of Network
- Services provided are not covered under my medical plan
- Medical insurance is not active

I agree to be financially responsible for all charges not covered by my medical insurance plan for services rendered by this physician of Diagnostic Group.

_____ _____

Patient Signature Date

No Show Policy

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will allow another patient who is waiting for an appointment to be scheduled in that time slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that time to other people.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a NO SHOW. Patients who do this three (3) or more times in a 12 month period may be dismissed from the practice and will be denied any future appointments.

Patients will be subject to a $35.00 fee for office appointment No Show.

The No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about no show fees should be directed to Diagnostic Group at 409.813.1677.

Please sign that you have read, understand, and agree to this No Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Diagnostic Group Integrated Healthcare System (DG) is part of Harbor Healthcare System, a healthcare services and management company based in Beaumont, Texas. Both DG and Harbor Healthcare System are owned by Qamar Arfeen, MD.

The purpose of this notice is to inform you that as part of your continued care, you may receive a referral for an additional medical service (or services), which, at your election, may be provided by or at one of the following other Harbor Healthcare System providers or facilities:

- Diagnostic Group Imaging – An outpatient imaging center that provides MRI, ultrasound, mammography and x-ray services
- Alliance Medical Services – A durable medical equipment provider
- Harbor Home Health – A home health provider
- Harbor Hospice – An inpatient and outpatient hospice services provider
- Beacon Hospice – An inpatient and outpatient hospice services provider

In connection with any referral for additional medical services, please note that you are not obligated to obtain these services from a Harbor Healthcare System provider or facility, and may choose to obtain any such additional medical services from any provider or facility of your choosing.

If you have any questions about the Harbor Healthcare System, its services, or locations, please call 409.813.2332

I have read and acknowledged the above.

_____ _____

Patient name (Please Print) Date

_____

Patient signature