SHOAIB
KHALIL
MD
INTERNAL MEDICINE

First Name _____ Last Name_____

Mailing Address _____ Social Security No. _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Email _____

Marital Status ___Single ___Married ___Divorced ___Widowed Sex __ M __F

Employer's Name _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Insurance Information

Name of Insurance Company _____

Policy ID Number _____ Group Number _____

Secondary Information

Name of Insurance Company _____

Policy ID Number _____ Group Number _____

Insurance Authorization and Assignment

I authorize Dr. Shoaib Khalil, Internal Medicine, to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for any visits at this office. I understand that I am responsible for all services whether covered by insurance or not.

Signature _____Date _____

ADULT HEALTH HISTORY

Are you currently or have you ever been treated for:

		Condition	Explain
		Asthma	
		Bleeding Disorders	
		Blood Pressure	
		COPD	
		Diabetes	
		Ear/Sinus	
		Fainting	
		Gastro-Intestinal Problems	
		Heart Disease	
		Kidney Disease	
		Learning Disorders	
		Menstrual Problems	
		Musculo-Skeletal	
		Psychological/Psychiatric	
		Seizures	
		Sickle Cell Disease	
		Sleep Disorders	
		Stroke	
		Surgery	
		Thyroid Disease	
		Serious Injury	
		Other	

Tobacco Use: ☐ Yes ☐ No (check all that apply) ☐ Current ☐ Previous
☐ Cigarettes ☐ Cigars ☐ Chew ☐ Dip
Quantity: _____ ☐ per day ☐ per week

Alcohol Use: ☐ Yes ☐ No (check all that apply) ☐ Current ☐ Previous
☐ Beer ☐ Wine ☐ Liquor
Quantity: _____ ☐ per day ☐ per week

Allergies

MEDICATION RECORD

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	AM PM

Medical Information Release Form (HIPAA RELEASE FORM)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be releases to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be release to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please Call [ ] my home [ ] my work [ ] my cell number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed_____ Date: ____/____/_____

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

The information you may release subject to this signed release form is as follows:

☐Complete Records	☐History & Physical	☐Progress Notes
☐Annual Wellness Exam	☐Lab Reports	☐Diagnostic Imaging
☐Pathology Reports	☐Vaccination Records	☐BMD Reports
☐Mammogram	☐Colon Screening	☐Diabetic Eye Exam

Release my protected health information to the following physician/facility:

Dr. Shoaib Khalil MD, PA
1900 E. Henderson Street Ste. B, Cleburne, Texas 76031
(P) 817-645-2322 (F) 817-645-2360

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Representative Printed Name of Representative

_____ _____
Date Description of Representatives Authority

Physician Assistant/or Nurse Practitioner Consent for Treatment

This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat, and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant and/or nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the physician assistant and/or nurse practitioner and request to see a physician.

_____

Signature

Financial Policy

To ensure that Dr. Shoaib Khalil, Internal Medicine Practice, has financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced:

- **Payment Responsibility** The patient or his/her legal representative is ultimately responsible for all charges incurred.
- **Payment Methods** We accept Visa, Mastercard, American Express, Discover, checks and cash.
- Non-covered Services Payment for all charges which are not covered by insurance is due and payable at the time of service.
- **Assignment of Benefits** Dr. Shoaib Khalil, Internal Medicine Practice, will bill primary insurance plans as a courtesy to its patients that provide the required insurance information and signs an assignment of benefits.
- **Prior Unpaid Accounts** A payment of prior outstanding accounts will be requested before being seen by the doctor or a specific payment arrangement may ne approved by the practice administrator.
- **Delinquent Accounts** Patients with unpaid delinquent accounts which have been written off to bad debt may be denied treatment if not medically required.
- **Third Party Litigation** The practice will not become involved in disputes arising from third party claims {i.e., automobile accidents, liability claims, etc.}
- **Collection Agency** Accounts which cannot be collected by Dr. Shoaib Khalil after normal inhouse collection procedures for further collection action. Any fees incurred will be patient's responsibility.
- **Refunds** Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients refunds will not be processed until all active or past due accounts are paid in full.
- **No Show Fees** Failure to call the office 24 hours prior to your scheduled appointment time will result in a $25.00 no show fee!

_____

Print Name

_____

Signature Date