FARZANA SAHI, M.D.
INTERNAL MEDICINE

HIPAA Right of Access Form for Family Member/Friend

I _____ direct my health care and medical services, providers, and payers to disclose and release my protected health information described below to these family members/friends:

1. **Name:** _____

   Relationship: _____

   Contact: _____

2. **Name:** _____

   Relationship: _____

   Contact: _____

3. **Name:** _____

   Relationship: _____

   Contact: _____

4. **Name:** _____

   Relationship: _____

   Contact: _____

Patient's Signature: _____ **Date:** _____

7777 Southwest Freeway, Suite 640, Houston, TX 77074 | Phone (713) 270-0477 | Fax (713) 270-7655

FARZANA SAHI, M.D.
7777 SOUTHWEST FREEWAY, SUITE 640, HOUSTON, TX 77074
PH: (713) 270-0477 FAX: (713) 270-7655

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ M.I. _____

DATE OF BIRTH _____ SSN _____

HOME ADDRESS _____

OFFICE ADDRESS _____

HOME PHONE _____ WORK PHONE _____

INSURANCE INFORMATION

CASH _____ MC _____ MCR _____ WC _____ PVT INS _____

NAME OF POLICY HOLDER _____

SOCIAL SECURITY NUMBER _____

INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE NUMBER _____

POLICY NUMBER _____ GROUP NUMBER _____

PERSON RESPONSIBLE FOR SERVICES _____

NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

WHO MAY WE THANK FOR REFERRAL _____

AUTHORIZATION FOR TREATMENT

I grant permission to Dr. Sahi and her medical staff to perform any and all medical/surgical procedures necessary for the diagnosis and treatment of my medical condition.

SIGNATURE _____ DATE _____

F. SAHI, M.D.
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HOUSTON, TX 77074
PH: (713) 270-0477

USES AND DISCLOSURES OF MEDICAL INFORMATION

We use and disclose medical information about you for treatment, payment, and health care operations.

Treatment: We may use and disclose your medical information to a physician or other health care provider in order to provide treatment to you. This includes coordination of your care with other health care providers related to your care.

Payment: We may use and disclose your medical information to obtain payment for service we provided to you. Payment includes submitting claims to health plans and other insurers, justifying our charges for and demonstrating the medical necessity of the care we deliver to you, determining your eligibility for health plan benefits for the care we furnish to you, obtaining precertification or preauthorization for your treatment or referral to other health care providers or entities subject to the federal Privacy Rules so they can obtain payment.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To Your Family & Friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, hospital location, and general condition or death to notify, or assist in the notification of (including identifying, or locating) a person involved in your care. We may also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, or similar forms of medical information.

Public Benefits: We may use or disclose your medical information as authorized by law for the following purpose deemed to be in the public interest or benefit:

- Public Health activities including disease and vital statistics reporting, child abuse reporting, adult protective services, and FDA oversight.
- Employers, regarding work-related illness or injury.

Restrictions: You have the right to request that we place additional restrictions on your use or disclosure of your medical information.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave a message with call-back number only
- ☐ Work Telephone
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave a message with call-back number only
- ☐ Written communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work or office address
- ☐ **Email Address:** _____
  - ☐ Other _____
  - ☐ _____

_____ _____

Patient Signature Date

_____ _____

Print Name D.O.B.

FARZANA SAHI, M.D., P.L.L.C.
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
7777 SOUTHWEST FREEWAY, SUITE 640
HOUSTON, TX 77074

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of our treatment. The following is a statement of our Financial Policy, which requires you to read and sign prior to any treatment.

Our fees are based on treatment received, regardless of the outcome. All patients must complete our information and insurance forms before seeing the doctor.

Full payment is expected at time of service.
We accept cash and credit cards (Visa, Discover, and MasterCard).
We offer extended payment options with prior approval.

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. As a courtesy we will attempt to file your primary insurance. However due to rising medical costs, we are unable to file second insurance plans. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you give us your insurance information and sign a claim form. Please be advised that if after 45 days your insurance claim has not been paid, you will receive a bill for the entire balance due upon receipt. Balance over 90 days will be turned over to a collection agency. Please be aware that some, and perhaps all, services provided may not be covered and not considered as reasonable, customary and necessary under the Medicare program or other insurance plans.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PRE-EXISTING CONDITIONS:

We will contact your insurance company in an attempt to get verification of coverage and a summary of your benefits. If your insurance carrier tells us of a pre-existing condition clause, you will be required to post a deposit of all services rendered until your insurance has paid all of your claims.

OUT-OF-NETWORK OR COBRA POLICY:

If you elect to go out of your network, you will be required to pay your service in full at the time of service. We can give you a receipt or send a copy of your claim to your insurance carrier on your approval.

REQUEST FOR MEDICAL RECORDS:

There will be a flat rate of $75.00 for copies of your medical records, whether specific or the chart in its entirety.

MISSED APPOINTMENTS:

Our policy is to charge a rate of $75.00 for EACH MISSED APPOINTMENT, unless you notify the office at least 24 hours prior to your scheduled time. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of responsible party

Date

MRZ MEDICAL

7777 SOUTHWEST FREEWAY, SUITE 640
HOUSTON, TX 77074

Please read this information carefully as there are policies and regulations that we have to follow to comply with insurance with regard to writing prescriptions or refilling medications.

We know that getting medication refilled is important to all of our patients, so we try to maintain the fastest turnaround time possible. We have a large volume of refill requests from our patients, so we ask that you request refills at least a week prior to running out of medication. Here are the steps you should follow when requesting additional refills.

First, consider whether you need a follow-up appointment or not. Many times we plan for your treatment to run out of refills when we expect that you should have returned for a follow-up visit.

- **All patients taking medication daily need to be seen in office every 3 months. Patients taking pain medications should follow up every month.** If you are overdue for an appointment, please call our office to make an appointment (713) 270-0477
- Next, you need to call your pharmacy and ask them to request a refill of your medication. It generally takes the pharmacy 24 hours to get the request to our office.

When we receive the request, we will review your chart before sending the refill.

- If you are on time with your follow-up appointment, we will send more refills directly to your pharmacy. Your pharmacy will inform you when your prescription is ready for pickup.
- If you are overdue for your follow-up appointment, we will inform the pharmacy that you need a follow-up appointment before we are able to refill your medication. Your pharmacy will inform you to make a follow-up appointment in order to be given additional refills.

Note: (please initial next to bullets)

- _____ **Please allow us 3 business days to get your medication refill sent to your pharmacy as we have a large volume of refills requesting every day.**
- _____ **Please follow up regularly in our office. All patients on daily medications need to be seen every 3 months. All patients taking pain medication need to follow up every month.**
- _____ **Being seen for a "sick visit" is not the same as being seen for a follow-up of your chronic condition.**

For example, a patient with High Blood Pressure (Hypertension) was seen last week for a sinus infection and is now requesting a refill. The last time the patient had their High Blood Pressure evaluation was 7 months ago. Since this patient is overdue for their 3-month follow-up visit, we would ask that the patient make an appointment to be seen.

Thank you for your collaboration and comprehension.

_____ _____

Patient's Signature Date Signed

_____ _____

Patient Name D.O.B.

MEDICATION LOG

Patient _____ **Birthdate** _____

Home Phone _____ **Work Phone** _____ **Occupation** _____

Pharmacy _____ **Pharmacy Phone** _____

MEDICAL/ALLERGY ALERTS:

DATE Rx	MEDICATION	DOSAGE	QTY.	FREQ.	REFILLS DATE AND INITIAL				STOP DATE

Notes: _____