Saba Shabnam, M.D.
Family Medicine & Wellness

1601 Lancaster Drive, Suite 160 Grapevine, TX 76051 | P: 817-510-9645 | F: 817-329-6622

Patient Information

Last Name: _____ First Name: _____ MI: _____
Preferred Name (if applicable) _____ Maiden Name: _____
Date of Birth: ___/___/_____ Sex: _____ Social Security Number: _____
Cell Phone: _____ Work Phone: _____
Email Address: _____
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Marital Status (circle one): S M D W
Race (circle one): White | Black or African American | American Indian or Native Alaskan | Hispanic | Asian | Latinx Native | Other
Employment Status (circle one): Active Duty/Military | Student | Disabled | Full-Time | Part-Time | Un-Employed | Retired | Self-Employed Other
Employer: _____ Occupation: _____
Employer Contact Number: _____

Guarantor Information (Leave blank, if responsible party)

Last Name: _____ First Name: _____ MI: _____
Preferred Name (if applicable) _____ Maiden Name: _____
Date of Birth: ___/___/_____ Sex: _____ Social Security Number: _____
Cell Phone: _____ Work Phone: _____
Email Address: _____
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____

Insurance Information

Primary Insurance: _____
Subscriber ID #: _____
Group Number: _____

Secondary Insurance: _____
Subscriber ID #: _____
Group Number: _____

Reference Source

How did you hear about us? (circle one): Family Friend | Colleague | Internet | Insurance | Walk-In | Other

Communication Preference

May we send you text messages to remind you of appointment times? (circle one): Yes | No
May we communicate with you by email? (circle one): Yes | No

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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 (PHI), to the physician/person/facility/entity listed below.

Patient Name: _____ **Date of Birth:** _____

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

All Records	Office Visit Notes	Radiology
Operative Reports	Labs	Medication Record
Hospital Reports	Progress Notes	Other: _____

Dates of Treatment to be released from _____ to _____

Release my protected health information from the following physician/facility

Name: _____

Address: _____

City, State, Zip Code: _____

Print Name: _____

Signature: _____

Date: _____

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164/508

Section 1: Patient Information

Name:	
Date of Birth:	

I, or my authorized representative, hereby authorize Mid Cities Health and their respective employees, agents, or subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to this designee identified below:

Section II: Authorized Designees (to whom the information will be sent)

Name:	Relationship:	
Street Address:	Telephone:	
City:	State:	Zip:

Name:	Relationship:	
Street Address:	Telephone:	
City:	State:	Zip:

Signature: _____ **Date:** _____

Email: _____

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Consent for Care and Treatment

As the patient or patient's representative, by signing below I hereby consent to necessary examination, procedures or treatments as prescribed by my physicians or her assistants. I understand that I am under the care and supervision of my attending physician.

Initial _____

Controlled Substance Medication Agreement

I, (**name**) _____, (**DOB**) _____,

Understand that my physician (hereinafter to refer to "physician") is prescribing a controlled substance medication as part of my treatment plan. This controlled substance agreement ("agreement") is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and/or management of pain. This requires cooperation, trust, and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled substance medication and the failure to continue to follow all terms will result in discontinuing the controlled medication and/or dismissal from our practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my physician. **Initial** _____
2. I will keep regularly scheduled appointments with my physician. There may be times when medication will need a refill between office visits. If that occurs, please call our staff at least 5 days before your medication runs out. Refill requests will only be taken Monday-Friday from 8am-5pm. Your physician or an on-call physician will not refill controlled medications after hours or on weekends. **Initial** _____

3. The controlled substance medication prescribed is being given to control pain and/or improve function. If there are any changes to your activity level of physical condition, the treatment may be changed or discontinued. You are responsible for notifying your physician of such changes.

Initial _____

4. I agree to act responsibly, including protecting and limiting access to these medications by keeping them in a safe place, and to dispose of any unused medication properly.

Initial _____

5. You are not to accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. It is essential that only one physician monitor and evaluate your use of controlled medication.

Initial _____

6. If you have another condition that requires the prescription of a controlled substance medication (tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing.

Initial _____

7. It is required that you use a single pharmacy for all prescriptions (provide pharmacy information below). You may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that our medications are known by a pharmacist and they are able to evaluate any concerns about interaction of medications.

Initial _____

8. I understand that lost, stolen, or misplaced prescriptions or pills will not be replaced. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific needs. To allow others to use your medication is illegal and dangerous. This type of behavior will not be tolerated by your physician or our practice. Proof of a police report will need to be provided should a theft occur.

Initial _____

9. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while also taking controlled medications, is extremely dangerous and potentially lethal.

Initial _____

10. I recognize altering a prescription in any way is against the law. Fabricating prescriptions or forging a provider's signature is also against the law. I realize that if I commit this law violation it will be reported to my pharmacy, local authorities and the Drug Enforcement Agency.

Initial _____

11. I agree and understand that my physician reserves the right to obtain random or unannounced prescription drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months thereafter depending upon the medication's dosage. If I fail to provide the sample when asked or if the results are inconsistent, I may forfeit the right to continue receiving care.

Initial _____

12. You should inform your physician of all medications you are taking including herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.

Initial _____

13. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions, if the physician feels it is necessary.

Initial _____

Pharmacy Name: _____

Phone Number: _____

If you have any questions concerning our medication agreement or we can assist you in any way, please feel free to call on our office staff.

I have read this agreement and consent to treat, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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Patient's Rights under HIPAA guidance:

I understand that:

- I can cancel this permission at any time. I must cancel in whiting and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42CFR Pt. 2), Genetics, HIV/AIDS and other sexually transmitted diseases.
- Once my health information is released the recipient may disclose or share my information with others and my information may no longer be protected by Federal and State Privacy Protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan or eligibility for benefits.
- Mid Cities Health will not share or use my health information without permission other than ways listed in given Notice of Privacy Practices or as required by law.
- A fee may be charged for providing the protected health information
- I have a right to receive a copy of this form, upon request.

Acknowledgement of Notice of Privacy Practice:

By signing below I acknowledge that I have reviewed or had explained to me PPCP Notice of Privacy Practices and agrees to continue my care with Mid Cities Health, LLC under said terms. I authorize the following persons to obtain medical information about me or my child and allow medical services to be rendered in my absence.

Printed Name _____

Relationship to Patient: _____

Signature: _____

Date: _____

Insurance Authorization and Financial Responsibility

My signature below authorizes Mid Cities Health, LLC to release any medical information necessary to process my or y dependent's insurance claim. I authorize any benefits due to be paid directly to Mid Cities Health, LLC/ Dr. Saba Shabnam, MD. Insurance companies only provides an estimate of covered benefits prior to delivery of services or materials. The estimate is not a guarantee of benefits. I understand that the cost of my visit may be subject to a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. I agree to be responsible for the payment of all balances on my, or my dependent's behalf. I understand that all the fees for professional services shall be paid at the time of service and are NON-REFUNDABLE. Any returned check will incur a $35 fee.

Please initial each line below to acknowledge practice policies.

_____ I understand I may be charged a **$50** cancellation/no-show fee for missing an appointment without 24 hour's notice

_____ I understand I may be charged a **$25** fee for any forms or paperwork to be completed by a physician

Signature:_____ Date_____