ZAID KHALIL MD

303 Maple Ave. W. # C Vienna, VA 22180

PATIENT REGISTRATION FORM
PLEASE PRINT

Patients Name **اسم المريض**	First الاسم الاول	Middle اسم الاب	Last اسم العائلة	Date of Birth تاريخ الميلاد السنة YYYY / اليوم DD / الشهر MM / /	
Home Address **العنوان**	Street الشارع	Apt. # رقم الشقة	City المدينة	State الولاية	Zip Code رمز المنطقة

Occupation المهنة	Social Security Number رقم الضمان الاجتماعي - -	Marital Status الحالة الزوجية S ----- M ----- W ----- D -----	Sex الجنس F ---- M ----	Home Phone رقم هاتف البيت ( ) -

Employer اسم مدير العمل	Address العنوان	Work Phone رقم هاتف العمل ( ) -
Spouse's Name اسم الزوج / الزوجة	Occupation/Employer المهنة	Work Phone رقم هاتف العمل ( ) -
Emergency Contact شخص اخر للاتصال به عند الحاجة	Relation to patient علاقته بالمريض Home Number رقم هاتفه ( ) -	Work Phone رقم هاتف العمل ( ) -
Patient's Cell Number رقم الهاتف الخلوي للمريض ( ) -	Referred By	Pharmacy # رقم هاتف الصيدلية ( ) -

Would you like to share your email address: البريد الالكتروني	Are you able to receive text Massages هل تستطيع استلام الرسائل Yes No

INSURANCE INFORMATION

Name of Primary Insurance اسم شركة التامين الاساسية	ID # on Card	Group #	Policy Type
Name of Secondary Insurance اسم شركة التأمين الثانوية	ID # on Card	Group #	Policy Type
Name of Primary Card Holder	Policy Holder's SS# - -	Date of Birth / /	----- Self ----- Spouse ----- Parent ------ Other
Name of Secondary Card Holder	Policy Holder's SS# - -	Date of Birth / /	----- Self ----- Spouse ----- Parent ------ Other

IF PATIENT IS A CHILD / MINOR – GIVE NAME OF PARENTS OR LEGAL GUARDIAN (S)

اذا كان المريض طفل او قاصر / الرجاء اعطاء اسم الأب او الأم او اسم الشخص الوصي عليه

Father's Name اسم الاب	DOB تاريخ الميلاد / /	Address العنوان	Work # رقم هاتف العمل	Home # رقم هاتف البيت ( ) -
Mother's Name اسم الام	DOB تاريخ الميلاد / /	Address العنوان	Work # رقم هاتف العمل	Home # رقم هاتف البيت ( ) -

I hereby authorize Dr. Zaid Khalil to apply for benefits on my behalf for covered service rendered by him. I request payment from my Insurance company be made directly to Dr. Khalil, I certify that the information I have reported with regard to my Insurance coverage is correct and further authorized the release of any necessary information, including medical information to my insurance company in order to determine the benefits to which I may by entitled. This authorization may be revoked by me or by my insurance company at any time in writing. If for any reason my insurance company does not pay this bill, I accept full responsibility for payment of same. In this event an action for collection is taken I agree to pay all collection fees and court costs there in.

Please Note: Services are rendered to you, the patient responsibility for payment to this office is with you, the patient and not the insurance company. This form has been specifically designed to assist in the completion for your insurance form. Our office however, cannot accept the responsibility for collecting your insurance claim or reimbursement schedules.

Patient's Signature or Beneficiary
توقيع المريض

/ /
Date تاريخ اليوم
السنة YYYY / اليوم DD / الشهر MM

Zaid Khalil MD
303 Maple Ave. W. # C Vienna, VA 22180

Patient Registration Form
Please Print

Medication Allergies:	Other Allergies:
Current Medical Problems / reason for today's visit:	Present Medication:
Other Physician Previously Treating you:	Previous or Other Medical Problems:
Previous surgeries or Hospitalizations and date(s):	Date of Last Visit to Previous Doctor?
Is the condition for which you are visiting Dr. Khalil related to: Employment ----- Accident (car, fell, etc.) ----- Other -----	Date of Accident / and place where it occurred:

Family only

Are you pregnant, planning a pregnancy or nursing a child □ Yes □ No
Do you have children? □ Yes □ No If yes how many? -----
Have you had any abortions or miscarriages □ Yes □ No If yes how many? -----

Do you smoke? □ Yes □ No □ Cigarettes □ Pipe □ Cigar
If yes for how long ? _____ How many a day ? _____
Interested in stopping ? □ Yes □ No
Do you drink regularly alcohol ? □ Yes □ No How many ounces / beer per day? _____
Do you drink regularly coffee ? □ Yes □ No How many cups a day? _____
Are you under a lot of pressure at work ? □ Yes □ No Please describe: _____

Personal Medical History

Have you ever had any of the following . CHECK ALL THAT APPLY….

□ Chest pain/pressure /tightening
□ Hypertension
□ Heart Attack
□ Stroke
□ Headaches
□ Glaucoma
□ Allergies
□ Depression
□ Blood in Stool
□ Asthma
□ Dizzy
□ Cancer
□ Diabetes
□ Arthritis
□ Difficulty Hearing
□ Memory Loss
□ Hemorrhoids
□ Kidney Disease
□ Shortness of breath
□ TB/Lung disorder
□ Ulcer
□ Skin disorder
□ Hepatitis
□ Cataracts
□ Digestive Problems
□ Frequent Urinary Infection
□ Other: _____

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High Blood Pressure						
Epilepsy						
Cancer						
Eczema / Psoriasis						
Heart Attack/Stroke						
Diabetes						
Asthma						
Hay Fever						

Immunization

Year of last received, if known

Smallpox _____ Typhoid _____ Influenza _____ Rubella _____
Tetanus _____ Polio _____ Pneumonia _____ Hepatitis _____

Zaid Khalil , MD. PC.

303 Maple Ave. W. # C
Vienna VA 22180
703 255 9850

Privacy Notice

The Depatment of Health and Human Services, Office of Civil Rights, under the Public Law 104-191 **(The Health Insurance Portability and Accountability Act of 1996) (HIPAA)**, mandates that we issue this new revised **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **(Standards for Privacy of Individually Identifiable Health Information IIHI)**; affecting our patients. You are urged to this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, Consent Agreement. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or health care operations (TPO).

Our Privacy Notice informs you of our use and disclosure of your **Protected Health Information (PHI)**, defined as: “any information, whether oral or recorded in any medium, that is either created or received by a health care provider; health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual”.

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed.

If you had a “personal representative” initiate as Authorization you may revoke that authorization at any time.

You, the patient have access to your health care information and may request to examine your information, may request.

Copies of your information, and under the law you may request amendments to your information. The principal will exercise professional judgment with regard to requests for amendment and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification or the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited laws that enforcement activities; and activities related to national defense and security. There are specific state laws that required the disclosure of health care health information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however, The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a “chain of trust” contact and monitor our business associates, contracts with us, we can not absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect you PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice.

Thank you

_____

Signature of Patient or Personal Representative Date:

_____

Name Printed

As or January 1 , 2009 Patient's Responsibility are:

1. Notify the office staff of any changes in address or insurance.

2. It is the patient's responsibility to know what your insurance coverage is, effective date and termination date.

3. All visits must be scheduled in advance, if you are not able to keep your appointment you must notify the office within 24 hrs or there will be a charge of $25.00 same day cancellation or no show fee.

4. All co – pays are due before services are rendered, this is required by your insurance company.

5. There is a fee of up to $35.00 for any form to be filled out or letter that requires the doctor signature.

6. Patients must notify the office 48 hrs. (Excluding weekends and holidays) of all medication that need to be refilled. All medication will be called in after 4:30 pm (it will take up to 48 hrs for meds to be called in).

7. Patients who need to be seen every 3 – 6 months for their medications and are not able to come in will be charged a $25.00 fee for prescriptions refills.

8. It is the patient's responsibility to provide the office with pharmacy phone numbers, the medication(s) and directions.

9. All HMO referrals need to be notified to the office staff within 3 – 5 business days before the date of your visit. Please provide all the other doctors information.

10. For the protection of patient's privacy, any results will not be mailed out. We will notify the patient if needed to follow up with the doctor.

Patient Signature: _____

Zaid Khalil M.D.
303 Maple Ave W # C Vienna, VA 22180
Phone (703) 255 9850
Fax (703) 255 9856

I _____ Date of Birth _____
t Patient Signature

Authorize that the following people may have the right to review my medical record and may speak directly with Dr. Khalil regarding my medical condition. In addition may have access to labs results, X-Ray or any other diagnostic testing.

1. _____ Phone # _____
Name Relation to patient

2. _____ Phone # _____
Name Relation to patient