**Bassem Said, MD**
1240 Central Blvd, Ste. A2
Brentwood, CA 94513
Phone: 925-516-4368 Fax: 925-516-4360

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's Last Name: | | First Name: | | | Middle: |
| Marital Status: S M Sep D W | Gender: M F | Age: | Date of Birth: | Social Security: | |
| Address: | | City: | | State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: | | Email: | |
| Employer: | | Employer Address: | | | |

| | | | |
|---|---|---|---|
| Patient Race: (Please Check One) | ◊ Amer. Indian or Alaska Native | ◊ Filipino | ◊ Other |
| | ◊ Asian Indian | ◊ Japanese | ◊ Prefer Not to Answer |
| | ◊ Black/African American | ◊ Korean | ◊ Unknown |
| | ◊ Chinese | ◊ Other Asian | ◊ White/Caucasian |

| | | | | |
|---|---|---|---|---|
| Preferred Language: | Hispanic Origin: | ◊ Non-Hispanic | ◊ Mexican | ◊ Unknown |
| | | ◊ Prefer not to answer | ◊ Cuban | |
| | | ◊ Puerto Rican | ◊ Other Hispanic/Latino/Spanish Origin | |

## EMERGENCY CONTACT

| | | |
|---|---|---|
| Name & Relationship: | Phone: | Cell Phone: |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Primary Care Physician: | Phone: |
| Referring Physician: | Phone: |

## ONLY COMPLETE THIS SECTION IF PATIENT IS A MINOR

| | | | |
|---|---|---|---|
| Person Responsible For Account: | | Date of Birth: | Social Security: |
| Relationship to Patient: | Address: (If Different from Above) | | Phone: |

**Consent for Treatment/Insurance Authorization:** I hearby authorize the release of medical or other information to my insurance company concerning charges/treatment provided to me by Dr. Said. I hearby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any other balance not paid by my insurance (excluding contractual allowances). If after 60 days, insurance payment has not been recieved, I understand that the charges are my responsibility and payable immediately. Additionally, I understand that I am responsible for providing a referral from my primary care physician if required by my insurance company. In the event that such a referral has not been provided to Dr. Said, I agree to pay for services at the time they are rendered.

I hereby authorize Dr. Said and his staff to perform diagnostic tests and provide necessary treatment for medical evaluation and healthcare for the aforementioned patient. I understand that primary medical care is the responsibility of the referring physician or another physician of my choice, and is not the responsibility of Dr. Said.

Signed (Patient or Parent/Guardian if Minor) _____ Date _____

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Required to bill your health insurance policy)

**Patient's Full Name:** _____

I hearby authorize Bassem Said, MD and his business associates to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that this authorization is voluntary (a signature is required to bill your health insurance directly).

Any and all of the following Health Information may be disclosed by Bassem Said, MD:

1. Medical Records
2. Claims/Billing Information

This Health Information may be disclosed to or obtained from: primary care, referring physician(s), Dr. Said and his business associates, health insurance carrier(s), and answering machines on home, work, or cellular phones. In addition, I consent to having my Health Information released to:

Spouse Significant Other Family Members Other (circle all that apply)

_____

(List anyone else you wish to have Health Information released to)

I understand that if the person or entity authorized above by me to receive my health Information is not a health plan or health-care provider, then the disclosed Health Inforation may no longer be protected from futher disclosure by state or federal law. This Health Information will be used only for the purposes of allwoing Bassem Said, MD and his business associates to pursue and receive reimbursement of claims from any and all responsible third parties, as allowed by the member's health plan or insurance policy. I understand that my health care will not be affected if I do not sign this form, however, I may be financially responsible for all services rendered if my insurance company refuses to compensate Dr. Said because he was unable to release my Health Information. Dr. Said and his business associates will not receive any financial or "in-kind" compensation as payment for disclosing the Health Information described above.

I understand that this authorization is indefinite unless a specific expiration date is listed here: _____
I also understand that I may revoke this authorization at any time by notifying Bassem Said, MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Bassem Said, MD in reliance on this authorization prior to the time he received my revocation. I understand that I have the right to receive a coopy of this authorization.

_____ _____
**SIGNED (PATIENT OR Parent/Guardian if Minor)** **DATE**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hearby acknowledge that I received or was offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the Patient Information Binder located in the waiting area (copies available upon request), and that I will be offered a copy of any amended Notice of Privacy Practices upon request at each appointment.

_____ _____
**SIGNED (PATIENT OR Parent/Guardian if Minor)** **DATE**

_____ _____
**PRINTED NAME** **TELEPHONE**

## Responsibility as a Patient

**Bassem Said, MD**
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Phone: 925-516-4368 Fax: 925-516-4360

**Patient's Full Name:** _____

INSURANCE

Health insurance companies routinely purchase contracts from other insurance companies without notifying the physician. As a result, we are not aware of every insurance company that has Dr. Said listed as a contracted provider. It is your responsibility to verify that Dr. Bassem Said is a covered provider for your health plan. Our acceptance of your insurance card and/or co-pay does not imply that we contract with your health plan. It is your responsibility to verify that your health plan will pay for services provided to you by Dr. Bassem Said. If your health insurance plan fails to pay for services rendered, the responsibility becomes yours.

_____
**Please Initial**

CO-PAYMENTS

If you have a Managed Care or PPO plan, your co-pay is due at the time of service.

_____
**Please Initial**

CANCELLATIONS/MISSED APPOINTMENTS FEE/RETURNED CHECK FEE

A 24-hour notice is required for all cancellations. If this amount of time is not given, a missed appointment or cancellation fee of $25 will be due and payable before your next appointment can be scheduled. There is a s $25 returned check fee.

_____
**Please Initial**

MEDICAL RECORDS AND FORM FEES

Your medical records are the property of Bassem Said, MD. You have the right to review these records and request copies of them. There is a minimum charge of $15 for the copying of records. Any form that requires completion by Dr. Said will have a minimum charge of $25. These fees are due at the time of the request.

_____
**Please Initial**

CONSENT FOR TREATMENT

I hereby give m permission and consent to Bassem Said, MD to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences. I have not been promised or guaranteed that the outcome will be successful. I am aware that the treatment for my condition is based on the information that I provide. If I have provided inaccurate, incomplete, or misleading information, I will accept full responsibility. Any identifying information provided such as address, telephone number, date of birth, etc. is correct and I agree to inform Bassem Said, MD and/or staff of any changes. I understand that if the information provided is inaccurate, I may be dismissed from the care of Bassem Said, MD.

_____
**Please Initial**

NOTICE TO CONSUMERS

Our Medical Practice is committed to providing you with high quality medical care. We understand that as a patient you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us, or our staff. If we are not able to answer your concerns to your satisfaction, please contact the Alameda-Contra Costa Medical Association at 510-654-5383. If the above suggestions are not satisfactory, or for any other reason, you may contact the Medical Board of Calfornia at 800-633-2322. Medical doctors are liscensed and regulated by the Medical Board of California (www.mbc.ca.gov).

_____
**Please Initial**

_____ _____
**SIGNED (PATIENT OR Parent/Guardian if Minor)** **DATE**

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## HEALTH HISTORY

**Todays Date:**

| Patient's Last Name: | First Name: | Age: | Sex: | Height: | Weight: |
|---|---|---|---|---|---|
| | | | | | |

Reason for Visit (Chief Complaint): How long have you had this issue, and what treatments have you had?

Allergies to Medications: If Yes, which medications are you allergic to? What type of reaction do you have?
YES NO

Medications - List all patient currently takes:
NONE ◊

Medical History - List past and current medical issues:
NONE ◊

Surgical History - List with dates:
NONE ◊

Alcohol Use? YES NO
If Yes, how many per week?

Occupation:

Exposure to Loud Noise
YES NO

Do you now or have previously used Tobacco products? YES NO
Packs per day? How many years? If you quit, when?

Family History:

Which Family Member:

Which Family Member:

Early Onset Hearing Loss? Y N _____ Bleeding Disorders? Y N _____

Thyroid Cancer? Y N Other? Y N

If patient is a CHILD, do they attend Daycare? Y N Are there Smokers in the household? Y N

Pharmacy Name and Location:

Accompanied by/Translated by: Relationship:

Review of Systems - To be Completed by Patient:

| Cardiovascular | Gastrointestinal | Respiratory | Infections | Psychiatric | Hematologic/Lymphatic |
|---|---|---|---|---|---|
| ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL |
| ___ Artificial Heart Valve | ___ Stomach Ulcer | ___ Asthma | ___ Hepatitis | ___ Depression | ___ Anemia |
| ___ Pacemaker | ___ Colitis | ___ Emphysema | ___ HIV/AIDS | ___ Anxiety Attacks | ___ Bleeding Problem |
| ___ Hypertention | ___ Liver Damage | ___ Other Lung | ___ Tuberculosis | ___ Other | ___ Enlarged Lymph Node |
| ___ Heart Attack (when?) | ___ Other GI Problem | _____ | ___ Other | _____ | ___ Other: _____ |

| Constitutional Symptoms | Musculoskeletal | Eyes/Ears/Nose/Throat | Neurological | Endocrine | Skin |
|---|---|---|---|---|---|
| ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL | ___ NORMAL |
| ___ Weight Loss | ___ Arthritis | ___ Glaucoma | ___ Stroke | ___ Diabetic | ___ Abnormal Scarring |
| ___ Fever | ___ Artificial Joints | ___ Hearing Aid | ___ Seizures | ___ Thyroid | ___ Poor Healing |
| ___ Other | ___ Other | ___ Plastic Surgery | ___ Other: | ___ Kidney Disease | ___ Other Skin Disorder |

Modifying Factors: ___Smoking ___Diabetes ___Blood Thinners ___Radiation Trmt ___Immunosuppressants ___Oral Steroid (Prednisone)
Why?

Reviewed by Bassem Said, MD