YASSIR SONBOL, MD PA
16605 SOUTHWEST FREEWAY MOB. 3, STE. 350
SUGAR LAND, TX. 77479
PHONE: 281-912-3866
Fax: 281-201-6545

Patient Name: ______________________________ **Date of Birth:** _______________

Address: ____ **Apt#:** ______________

City: ____________________________ **State:** _____________ **Zip:** ______________

Home Phone: ________________________ **Cell Phone:** _____________________

Social Security #: _______________________ **Height:** _______ **Weight:** ________

Please check one of the following:

Gender: ☐ **MALE** **or** ☐ **FEMALE**

Marital Status: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**

Please check one of the following:

ETHNICITY

☐**American Indian/ Asian** ☐ **Asian** ☐ **Two or more races**
☐**Black/ African American** ☐ **White/Caucasian** ☐ **Some other race**
☐**Native American/ Hawaiian**

Please check one of the following:

Race

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Unknown/Refused**

- -

Referring Doctor: __________________________ **Phone #:** _______________

Reason for Referral: ________________________________

Primary Care Physician: ____________________ **Phone #:** _______________

Has patient had a recent EKG or ECG? If so where? ____________________

If not referred from another physician, how did you hear about us?

☐**Sugar land Community Magazine** ☐**Facebook**
☐**Fort Bend Focus** ☐**Internet**
☐**Absolutely Brazos** ☐**Other:** _________________________

Insurance Information

Primary Insurance: ______________________________ **Phone:** _______________________

Member ID: __________________________________ **Group #:** _________________________

Insurance Holder(*if different from patient*)_____________________ **DOB:**_____________

Address: ____ **Apt #:** ___________

City: _________________________ **State:** _________________ **Zip:** _________________

Secondary Insurance: _____________________________ **Phone:** ______________________

Member ID: _________________________________ **Group #:** __________________________

Insurance Holder(*if different from patient*)_____________________ **DOB:**_____________

Address: ____ **Apt #:** ___________

City: _________________________ **State:** _________________ **Zip:** _________________

Emergency Contact Information

Name: ____ **Relationship:** ____________________

Address: ____ **Apt #:** ______________

City: ___________________________ **State:** ____________________ **Zip:** _______________

Home Phone: _____________________________ **Cell Phone:** ___________________________

Signature:_______________________________________ **Date:** ______________________

Medication List

	Name of Medication	Dosage (mg/mcg)	How many times per day?	Form *(pill, liquid, inj..)*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Pharmacy Information

Retail Pharmacy: ***(example: Walgreens,CVS, etc.)***

Name: ___________________________________

Phone : _________________________________

Fax #: __________________________________

Address:________________________ ***City:*** ___________ ***State:*** _______ ***Zip:***______

Mail Delivery Pharmacy***: (example: Medco/Express Scripts, etc.)***

Name: ___________________________________

Phone : _________________________________

Fax #: __________________________________

Address:________________________ ***City:*** ___________ ***State:*** _______ ***Zip:***______

Signature:___________________________________ ***Date:*** _________________

<u>Vein Screening Questionare</u>

Patient Name: ______________________________ **Date:** ____________

(Please check ones that apply to you):

Varicose vein problems	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Leg or Ankle Ulcers	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Spider Veins	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**

Do you experience any of the following in your leg(s)?:

Aching/Pain	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Heaviness	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Tiredness/Fatigue	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Itching/Burning	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Swelling	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Cramps	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Restless Legs	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Throbbing	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**
Skin or ulcer problems	☐ **Y**	☐ **N**	**Leg:** ☐**R** ☐**L**

Do you do any of the following to improve the discomfort in your leg(s)?:

Take medication for pain:	☐ ***Y***	☐ ***N***	***What?*** ________________
Elevate your legs:	☐ ***Y***	☐ ***N***	***What?*** ________________
Wear support hose:	☐ ***Y***	☐ ***N***	***How long?*** ____________

Personal and Family History:

Does anyone in your family have Varicose Veins?	☐ **Y**	☐ **N**	**If so who?** ____________
Have you ever been pregnant?	☐ **Y**	☐ **N**	**If so how many times?** _______
Do you sit or stand for long periods of time?	☐ **Y**	☐ **N**	**For how long?** __________
Do you exercise regularly?	☐ **Y**	☐ **N**	**How often?** __________

Request for Medical Record Release

YASSIR SONBOL, MD PA

Board Certificate in Cardiology and Interventional Cardiology

Methodist Office Building #3 Suite 420

16605 SOUTHWEST FREEWAY MOB. 3, STE. 420
SUGAR LAND, TX. 77479
PHONE: 281-912-3866
Fax: 281-201-6545

The following individual has asked us to request that his medical records be released and forwarded to our office.

Patient: ____

Birthdate: ____

Social Security #: ____

In order for us to fully evaluate the patients' health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include all lab reports as well as office notes.

Thank you for expediting this request. Please mail or fax these records to our office address shown above.

I herby authorize the release of all necessary medical records to *Dr. Yassir Sonbol, MD.* I wish for them to be forwarded as soon as possible.

Paient Signature: ______________________________ **Date:** ______________

Patient Address: ____

HIPPA NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from designated third-party payers.*
- *Conduct normal health care operations such as quality assessments or evaluations and physician certifications.*

We will not use or share your medical information for any other reason unless you give us written permission. You may withdraw your permission in writing at any time. Your permission for us to use or share your information will end when we get your written notice withdrawn your permission.

I understand that I may request in writing that this organization may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Your rights. You may ask us in writing to do any of the following. We will decide if it can be done based the Privacy Protection Standards outlined in HIPAA.

- *You may ask us to use or share your medical information.*
- *you may ask us to contact you about your medical information privately in a different way or different place than we are currently doing.*
- *You may ask to see or obtain copies of your medical information. You may be charged for copies.*
- *You may ask us to correct your medical information.*

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

***Complaints**: If you believe we have not protect your right to privacy, you have the right to complain to us or the Secretary of the U.S Department of Health and Human Services.*

I understand and accept the terms of YASSIR SONBOL, MD PA practice.

Signature: ____ *Date:* ________________

Cancellation Policy/No Show Policy For Dr. Appointments

Cancelation/No show policy for doctors appointments

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule your visit, due to a seemingly "full" appointment book.

(Patient/Guarantor initial ____________)

We also reserve the right *to charge for a missed appointment* when you fail to provide notice that you will not honor your appointment without good cause. Please call our offie *24 business hours* prior to a scheduled appointment to avoid charges *(excludes weekend).* Your failure to to timely cancel an appointment will result in a charge of *Thirty Dollars ($30.00)* for missed medical appointments. This assessment becomes your personal and individual responsibility and cannot be charged to your insurance or third-party carrier.

(Patient/Guarantor initial ____________)

For your convenience, accounts can be paid using MasterCard, Visa, and Discover Card, as well as check and cash. We thank you for choosing Yassir Sonbol, MD PA **for your Cardiology care and look forward to serving you.**

______________	______________	______________	______
Print Patient Name	**Date of Birth**	**Patient Signature**	**Date**

PATIENT ACCOUNT BILLING AND DISCLOSURE NOTICE

Please be advised that *Yassir Sonbol MD PA*, maintains a Patient Billing and Disclosure Policy as of 01/01/2017, (the "Policy") which is outlined below. You should read the Policy and ask any questions you may have regarding its effect or operation. By your signature below, *Yassir Sonbol MD PA* herby acknowledges your receipt, understanding and consent to the following terms and conditions.

Once we have received payment in full from your primary insurance (and/or secondary insurance carrier if applicable). You will receive an invoice for that portion of the invoice balance which remained unpaid by any insurance or third party carrier ("Patient Owed Balance"). Such balances, for example, are usually for *unpaid copayments, non-medical deductibles or non-covered services* per your particular plans benefits.

We will bill you for all charges for a particular date of service that has been paid by your insurance or third party carrier(s). You may still have claims that are being processed for other dates of service. However, we invoice you based on a specific date of service for which insurance payments have been received in full in order to clear the remaining balance for the date of service. Your INSURANCE CO-PAY and any PATIENT OWED BALANCE are DUE IN FULL at each visit. If these patient responsibilities cannot be met then we will have to reschedule your appointment. For information on your CO-PAY, call your insurance carrie. For information on your PATIENT OWED BALANCE, pleas call Kiren Garcia at 281-912-3866.

Please read the following carefully.

You should receive an Explanation of Benefits (EOB) from your insurance detailing your patient responsibility (patient owed balance) for your services. Please pay your balance in full from this initial insurance notice. *Yassir Sonbol MD PA* will send out 1-3 invoices reflecting the Patient Owed Amount depending on the remaining balance. If payment in full on your Patient Owed Balance is not received within a thirty (30) day period, your outstanding account may be turned over to a collection agency without any additional notice to you. Invoices, which are turned over to a collection agency, are immediately deemed Delinquent Accounts. Any Delinquent count is discharged from further care and services until the Delinquent Account is paid in full. ADDITIONALLY, IF YOU DESIRE OUR SERVICES AND CARE IN THE FUTURE YOU MUST REINSTATE YOUR ACCOUNT BY PAYING ALL COLLECTION FEES AND COST INCURRED BY YASSIR SONBOL MD PA. THESE FEES NORMALLY INCLUDE 35% CHARGED BY THE COLLECTION AGENCY THAT RECOVERED PAYMENT OF YOUR OUTSTANDING AND UNPAID ACCOUNT. WE RESERVE THE RIGHT TO REFUSE FUTURE SERVICES UNTIL SUCH FEES AND COSTS ARE PAID IN FULL. ALSO, PLEASE NOTE THAT PAYMENT OF SUCH FEES ARE IN ADDITION TO ANY NEW SERVICES RENDERED BY *YASSIR SONBOL MD PA.*

For your convince accounts can be paid using your MasterCard, Visa and Discover Card as well as check and cash. We thank you for choosing *Yassir Sonbol MD PA* for you cardiology care and look forward to serving you.

Print Patient Name	Date of Birth	Patient Signature	Date