ADULT MEDICAL SERVICES PC
6645 Main St. Suite A, Williamsville, NY 14221
(716) 276-8726 (Office)
(716) 276-8730 (Fax)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date:_____

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PRIMARY INSURANCE

Person responsible for Account _____
Last Name First Name Middle Initial

Relation to patient_____DOB_____SSN_____

Address (if different from patient's)_____Phone_____

City_____State_____Zip_____

Insurance Company_____

ID Number_____Group Number_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? YES NO

Person responsible for account_____
Last Name First Name Middle Initial

Address (if different from patient's)_____Phone_____

City_____State_____Zip_____

Insurance Company_____

ID Number_____Group Number_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed, or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

DOB_____Sex: M F SSN:_____

Home Address: _____

Phone: Home:_____ Cell_____

Person to be notified in Emergency:

Name/Relationship: _____

Home Phone_____ Business Phone_____ Cell Phone_____

Previous Physician_____Phone_____

Address_____Date of Last Visit_____

Your Employer_____

Address_____

Spouse's Employer_____

Address_____

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PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient _____
Last Name First Name Middle Initial

Address_____

Date of Birth _____

ADULT MEDICAL SERVICE is authorized to furnish to/receive from (circle desired choice):
Recipient/Discloser: _____

For the Purpose of: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records r copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMSATION which may include information concerning mu treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapists, psychologists, if any.

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release Adult Medical Services, Inc, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Adult Medical Services, PC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on __/__/__(Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____
Patient Signature (Parent's Representative if minor) **Date**

_____ _____
Witness Signature **Date**

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

☐ **Not satisfied with Provider (which provider?)_____**

☐ **Not satisfied with Staff (which staff member?)_____**

☐ **Moving out of the area_____**

☐ **Other (please describe)_____**

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Sameer Mamnoon, MD **Hassan Fares, NP**

INSURANCE WAIVER

I, _____ state my health insurance is _____.

Should my insurance not cover my office visit, I agree to pay the bill for this visit in full.

_____

Name

_____

Witness