Abdul Qadir, MD

REGISTRATION

Please Print

Patient Information			
Date:	Home Phone:	Cellphone: ( )	
Last Name:	First Name	Middle:	
Social Security No.	Driver's License No.	Date of Birth	
Street Address:	E-Mail Address:		
City:	State:	Zip Code:	
Sex: Male of Female	☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____years		
Employer Name/School Name:			
Employer/School Address:			
Occupation:	Business Phone:		

Responsible Party Information			
Last Name:	First Name	Middle:	
Social Security No.	Driver's License No.	Date of Birth	
Street Address:	E-Mail Address:		
City:	State:	Zip Code:	
Employer/School Address:			
Occupation:	Business Phone:		
Relationship to Patient:			

Medical Insurance	
Copy of Insurance Card Located Inside Chart	
Emergency Contact:	Phone:
How did you learn of our practice?	

Authorizations

Insurance Assignment and Release

Assignment of Medical Benefits – Agreement to Remain Responsible – Please Read Completely

I hereby make assignment of my medical benefit to Abdul Qadir, MD, 1177 N. Highland Ave., Aurora, IL 60506. As a stipulation of the extension of credit granted to me, and in exchange for the Medical Practice processing my claim(s), I agree to pay for insurance co-payments and co-insurance at the time service is rendered. I also agree to make full payment on all claims and any balances relating to claims which remain outstanding and / or unpaid by my insurance company which are older than 60days from the date service was rendered (regardless of the status of the claim). I specifically agree to verify acceptance of my medical claim with my insurance carrier no later than 30 days from the date service is rendered and report any problems to the billing department of (630) 301-7366. Should I fail to render payment for any outstanding balance that is older than 90 days from the date service is rendered, I will allow the assessment of a monthly statement production fee of $10.00 to defer the administrative overhead associated with my past due balance. I understand and agree that there will be additional fees assessed to my account for returned checks, miscellaneous research, copy of records, missed appointments, duplicate claims submissions inaccurate claim information provided and skip trace fees. Delinquent accounts (accounts that contain dates of service older than 90 days) that are transferred to a collection agent will be charged a non-refundable administrative collection processing fee of $169.00 and backup interest compounded monthly at a rate of 1.75% until the account is settled in full. I specifically agree that all fees assessed to my account and all determinations of the appropriateness of provider discounts applied to my account will be determined solely by the medical practice regardless of the determination of my insurance carrier. I authorize this medical provider or the agents thereof to release and / or distribute any and all medical information necessary for settlement of mine or my dependent's claim(s). I also authorize and request payment of medical benefits directly to my physician(s). I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I also agree that a photocopy of this form may be used in lieu of the original.

Signature: _____ Print Name: _____ Date: _____