ISMAIL DAIRYWALA, MD
18220 Tomball Parkway, Suite 230
Houston, TX 77070

Name: ________________________________ Last name:_____________________________

DOB:_______________________ SEX: M F SS#: __________________________________

Mailing address:____

City: __________________ state: ______________________________________ zip_________

home phone # _____________________________ cell:_______________________________

E-mail: ____

Emergency contact: ____________________ Relationship: __________ Phone:_____________

Pharmacy: _________________________________ Phone#______ _______________________

Primary Doctor: ______________________________ Phone#____________________________

PLEASE PROVIDE INFORMATION ON THE PRIMARY INSURED:

Name: _______________________________ Relationship: Self Spouse (circle one)

Insurance Name: ____

ID: ____ Group: ________________

Secondary insurance:

____

ID: ____ Group: ______________________

I have insurance as above and assign benefits directly to Ismail Dairywala, M.D. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible financially for all charges whether or not paid by insurance. I hereby authorize the Dr Dairywala to release all information necessary to secure the payment of benefits.

Signed: ___________________________________
Printed name: ____________________________
Date: ____________________________________

Northwest Cardiovascular Clinic, P.A.

General Interventional Cardiology
_______________________Ismail T. Dairywala M.D., FAAC________________________
18220 Tomball Parkway #230, Houston TX 77070
Phone: 281-807-5253
Fax: 281-477-7452

MEDICAL RECORDS RELEASE FORM

TO: ____
(Physician or Clinic you are sending this to)

FROM: ____

DOB: _____________________________________ SSN: _________________________________

By signing this form I authorize you to release confidential health information about me, by releasing a copy of my medical records as requested:

[ ] Radiology reports **[ ] Laboratory** **[ ] Progress notes** **[ ] H & P**

[ ] All Medical records **[ ] ____**

HIV / AIDS: I Consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:_______________ Date: _____________________.**

Release my protected health information to the following person(s)/entity:

Ismail Dairywala, M.D,
18220 Tomball Parkway, #230
Houston, TX 77070

Patient signature: ____ Date: _____________
(or patient , guardian or legal representative)

Please fax records to 281-477-7452

Northwest Cardiovascular Clinic, P.A.

General Interventional Cardiology

________________________Ismail T. Dairywala M.D., FAAC________________________

18220 Tomball Parkway #230, Houston TX 77070 TEL:(281)807-5253 FAX: (281)477-7452

POLICIES AND PROCEDURES

We welcome you to our practice. In order to make things run smoother and in a timely manner, we would like to share some of our policies and procedures. These are provided specifically for our convenience and we appreciate your support in this matter.

We require a **72-hour** notice for all refill requests.

We do not accept workers comp, third party payers, or accident related cases.

We strive very hard to accommodate all our patients into our practice; therefore, we appreciate a prior notice of cancellation or changed appointments. All our scheduled patients will be seen before any worked in patients.

A fee of $25.00 will apply after 3 missed appointments.

There will be a fee for copying all medical records in order to cover our cost of paper and personnel.
There will be a $25.00 charge for all forms requiring a physician signature, requests will be handled in a timely manner.

We reserve the right to deny service to anyone portraying unacceptable behavior.

Again, we truly appreciate all of your cooperation and understanding. For any concerns or questions, feel free to talk to our staff.

Signature ______________________________ Date__________________________

Northwest Cardiovascular Clinic, P.A.

General Interventional Cardiology

_________________________Ismail T. Dairywala M.D., FAAC_________________________

18220 Tomball Parkway #230, Houston TX 77070 TEL:(281)807-5253 FAX: (281)477-7452

Acknowledgment

Patient Name: ____

Date of Birth: ____

Social Security Number: _____________________________________

I acknowledge that Northwest Cardiovascular clinic, P.A. provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ _____________________

Patient signature Date

____ ______________________

Personal Representative Signature (if applicable) Relationship to patient

Medicare Authorization/ Assignment of Benefit

I request that payment of authorized Medicare benefits be made to or on my behalf to Dr. Ismail Dairywala, Northwest Cardiovascular Clinic, P.A. for any services furnished to me by its provider. I authorized any holder f information about me to the centers for Medicare/Medicaid services and its agents any information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or somewhere else on other approved claim forms, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.
Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_________________________________ _____________________

Patient's Printed Name Date

____

Patient's or Representative's Signature

Ismail T. Dairywala, MD

Assignment of Benefits

I certify that the information I have given to **Ismail T. Dairywala, MD** is true and correct to the best of my knowledge. I promise to pay **Ismail T. Dairywala**, MD all charges and expenses for services provided to me in accordance with the current fees and charges to the extent that the fees and charges are not covered or paid by my insurance(s).

I request that payment of authorized benefits under any private or government insurance program be made on my behalf to **Ismai l T**. **Dairywala, MD**. for services furnished to me by the provider of **Northwest Cardiovascular Clinic, PA**. I authorized any holder of medical information about me to release to third party payers and its agents any information needed to determine benefits if applicable**. Ismail T. Dairywala, MD** may pursue collection of these benefits in my name or in the name of Northwest Cardiovascular Clinic, PA. I also authorized the use of a copy of this authorization agreement in place of the original. I understand that procession of medical insurance does not relieve me of financial responsibility to **Ismail T. Dairywala, MD.** I will personally be responsible for all charges for services that are not covered by my health insurance.

____________________________________ _________________________

Patient signature or Guardian Date