Ambareen Salam, M.D

Patient Consent and Release Forms

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by Internal Medicine Associates of Texas and understands and consents to the review and use of his/her medical records by our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Internal Medicine Associates of Texas to furnish information concerning my medical condition and treatment thereof to my insurance carriers. I also assign insurance benefits to be paid on my behalf to Internal Medicine Associates of Texas by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by Internal Medicine Associates of Texas. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me, in writing.

AUTOMATED CALLS: I consent to receive automated phone calls regarding appointments, including patient portal communication. ___ **YES** ___ **NO**

MEDICATION HISTORY: I consent that my medication history may be downloaded from Sure Scripts to properly manage my care. ___ **YES** ___ **NO**

VACCINE HISTORY: I consent that my vaccines may be downloaded from IMMTRAC through the Texas Department of Health Services (DSHS). ___ **YES** ___ **NO**

Signature **Date of Birth** **Date**

Internal Medicine Associates of Texas, 7777 Forest Lane Suite C-650, Dallas, TX 75230
Phone: 972-566-8899, Fax 972-566-5775

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may use and disclose, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPPA)

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with this important information. For a complete guide of the privacy practices of our office regarding your health information rights, please review the notebook in the waiting room. If you would like a copy to retain for yourself please request this from our front desk staff.

I acknowledge that I have been presented with the Notice of Privacy Practices as well as the Office Protocol and understand my responsibilities.

Signature **Date of Birth**

Signature of Patient or Legal Representative **Date**

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