New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

Patient Name: _____ Date: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Driver's License#: _____ Social Security#: _____

Date of Birth: _____ Age: _____ Email: _____

Home #: _____ Cell#: _____ Work#: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Marital Status/(State Spouse Name if Applicable): _____

Insurance Carrier: _____ Ins. ID: _____

Person to Notify in Case of an Emergency: _____

Relation _____ Phone #: _____

Name of person responsible for payment: _____ Date of Birth: _____

SSN#: _____ Driver License #: _____ Phone#: _____

Address: _____
(Street) (City) (State) (Zip)

How were you referred to our office? _____

I hereby authorize payment of my insurance benefits to be paid directly to Dr. Atif Iqbal. I understand that I am financially responsible for charges regardless of insurance benefits. I am also responsible for any collection, legal, or any other cost incurred, should this be necessary on my account because of non-payment. I am aware that there will be a $25 fee for any returned payments. I hereby authorize release of my medical information for the process of insurance benefits for any medical/surgical services rendered.

Patient Signature: _____ Date: _____

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

Dear Patient,

As a courtesy to you, we will attempt to verify your insurance benefits prior to your surgery; however, your insurance company makes the final determination on how your claim is paid after they receive the claims by the various providers of service.

There are probably hundreds of different insurance policies on the market today. The language used to describe benefits is always consistent from one insurance to another. For Instance, an insurance company may claim to pay 80% of reasonable and customary, which usually means 80% of billed charged, but could also mean 80% of the insurance company's fee schedule.

Often, the customer service representatives at the insurance companies are unclear to what exactly the benefits of the policy will mean to the patient in actual out of pocket dollars and cent. In addition, there occasions when a provider of service is not part of your network. Some of these providers could include the Radiologist who reads your x-rays or Pulmonologist who interprets your pulmonary function test. These providers could be paid at a different rate than in the network providers.

Therefore, it is advisable that you review your benefits in your insurance company handbook and ask questions of your insurance carrier, as you will be responsible for whatever you're out of pocket expenses are according to the provisions of your policy.

ASSIGNMENT OF BENEFITS

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment. However, the patient is responsible for all fees, regardless of insurance coverage.

Insured's or Authorized Persons

Signature _____ Date _____

I request that payment of authorized medicare/other insurance company benefits be made on my behalf to Atif Iqbal, M.D. for any services furnished by me, by the party who accepts assignment/physician. Regulations pertaining to Medicare assignments of benefits apply.

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

ASSIGNMENT OF BENEFITS FORM

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health-medical plan, to issue payment check(s) directly to Atif Iqbal, M.D. for any services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZE TO RELEASE INFORMATION

I hereby authorize New Life Surgery to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopying of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from New Life Surgery on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

PATIENT FINANCIAL RESPONSIBILITY

If you are unable to keep your scheduled appointment, you are requested to notify the office during regular business hours at least 24 hours prior to your appointment time. Please note that weekend are not considered a business day. If your appointment is on a Monday, you must cancel by Friday before the weekend.

If you do not provide 24 hour notice you miss your appointment, be deemed as a no show, and you will be required to pay $50.00 in order to reschedule your appointment. This fee is your responsibility; it is not covered or reimbursed by insurance.

All candidates for bariatric surgery are required to have a psychosocial consultation with a program Psychologist. If you are a bariatric patient, you will not be rescheduled for another appointment until the Psychologist is paid.

I agree to abide by the terms of this agreement and accept full personal responsibility to pay all fees incurred. Once the fees are paid, the doctor will determine if the appointment is to be re-scheduled and you will receive a call.

_____ _____

Printed Patient Signature Date

_____ _____

Patient Signature Date

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____

Date of Birth: _____/_____/_____

To: _____

_____

_____

I hereby authorize you to release my medical records to:

Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708
P: 714-599-8222 F: 714-599-8223

Any information including the diagnosis and records of any treatment or examination rendered to me during:

From: _____ To: _____

If you have any questions, please feel free to contact our office.

_____ _____

Patient Signature Date

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

I, _____ agree to have the staff of this office access my chart, and/or contact me for medical and clerical follow up needs. This will be done by office visits, phone, e-mail, fax or any other means deemed appropriate.

I understand that all of my records, Pre-Operative, Peri-Operative, and Post-Operative will be maintained in a confidential database.

_____	_____
Printed Patient Signature	Date
_____	_____
Patient Signature	Time
_____	_____
Address	City State Zip
_____	_____
Witness	Date

New Life Surgery
Atif Iqbal, M.D. FACS, FASMBS
18225 Brookhurst Street, Ste 5
Fountain Valley, CA 92708

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", or "Patient Guardian", shall be understood to mean _____.
"Physician" shall be understood to mean Atif Iqbal, M.D.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician. I, or the Patient Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the physician.

Should I initiate or pursue a meritorious medical malpractice claim against the physician, I agree to use expert witnesses (with respect to issues concerning standard of care), only Physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the ASMBS and Board Certified. I agree that the expert will be obligated to adhere to the guidelines or code of conduct defined by the ASMBS. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to these provisions.

In further consideration, the appointed physician must also agree to exactly the same above referenced stipulations. Each party agrees that a conclusion by a specialty affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

I, the patient, or my Guardian, and the Physician agree that this Agreement is binding upon them individually and their representative successors, assigns, representatives, personal representatives, spouses, and other dependents. Physician and Patient, or Guardian, agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery, or any other theory of recovery. Patient, and/or Guardian, acknowledges that he/she has been given ample opportunity to read this Agreement and to ask questions about it.

_____

Effective from Date of Treatment

_____ _____

Patient Signature Physician Signature: Atif Iqbal, M.D.