Aamir Ahmed Faruqui, MD, Inc.

Pulmonary, Critical Care and Sleep Medicine

Patient Name: _____
DOB: _____

CO-PAYMENT AND COLLECTION POLICY

We are required by law, and your health plan, to collect co-pays at the time of service. Co-pays are required each time you are seen by the physician.

Your co-payment is established by your health plan and is explained in your benefits handbook. Your specific co-payment is printed on your insurance card. If you have questions or concerns about your co-payment requirements, please call your insurance carrier.

INSURANCE REIMBURSEMENT AND BILLING PROCEDURE

BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you. Each month you will receive your current balance and any charges incurred during the statement month. We will bill your primary and secondary insurance carrier for you. For us to be able to bill your insurance carrier, you must sign below. NAVIGANT, our billing company, will bill your insurance carrier, then the responsibility for handling issues with insurance reimbursement rests with you. Please note that you are ultimately responsible for payment of your bill with Aamir A. Faruqui, MD, Inc.

When you receive our monthly statement, payment is expected within thirty (30) days. Account balances are considered delinquent after sixty (60) days. If statements are not paid after this sixty (60) day period, your account will be transferred to our collection agency (Frost-Arnett), unless alternative payment arrangements are made with Aamir A. Faruqui, MD, Inc.

If Aamir Faruqui, MD is NOT contracted with your insurance carrier, you are considered a "self pay" patient and payment is due in full at the time of service. Self Pay patients will receive a discount off the standard fee schedule as long as payment is made at the time of service.

RETURNED CHECK FEE: There will be a $15 returned check fee.

NO SHOW APPOINTMENT FEE: There will be a $40 fee charged for appointments not canceled or rescheduled within 24 hours of the appointment.

SUSPENSION OF CARE (EXCEPT EMERGENCY CARE): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received.

Contact our billing company at 1-855-235-3497, M-F 8 AM – 5 PM PST with any questions.

My signature below indicates that I have read, understood and agreed to the Patient Financial Policy of Aamir A. Faruqui, MD, Inc.

Patient/Guardian Signature :_____ Date:_____

Patient/Guardian Name:_____

Patient Name: _____

Date of Birth: _____

Release of Financial and Medical Information

I hereby authorize release of any information, including the diagnosis and records of treatment or examination, rendered to my insurance company or companies. I hereby authorize payment directly to Aamir A. Faruqui, MD the insurance benefits otherwise payable to me. I understand that the responsibility for payment of services provided in this office for myself or dependents are mine.

I agree that the individuals listed below may receive medical information regarding my condition by phone or by written communication.

Please list any and all names and phone number of individuals that we may contact regarding you:

1. _____

2. _____

3. _____

4. _____

Patient Signature: _____

Guardian Name, Phone and Signature:

_____

AAMIR A. FARUQUI, MD, INC.
Pulmonary, Critical Care and Sleep Disorders
2121 Ygnacio Valley Road, Suite E-104, Walnut Creek, CA 94598
Phone (925) 934-2121 FAX (925) 934-2112

NOTICE OF PRIVACY PRACTICES

We are committed to protecting the privacy of you and your family. We will share information about you only with those who need to know it and who are permitted by law to receive this information. [*Guardians and personal representatives should be aware that the words "you "and "your" in this notice refer to the consumer not to the guardian.*] We are required by both federal and state law to protect the privacy and confidentiality of protected health information that may reveal your identity, and to provide you with a copy of this notice which describes the privacy practices of our agency and staff. A copy of our current notice will be given to you by asking for one at the time of your next visit. *If you have any questions about this notice or would like further information, please contact www.hhs.gov.*

I acknowledge review of the Notice of Privacy Practices for Dr. Aamir A. Faruqui and I may request a written copy if needed.

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

Name: _____ **DOB:** _____

EPWORTH SLEEPINESS SCALE

How likely are you to feel sleepy in the following situations: compared to just feeling tired. This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation.

0= would never feel sleepy

1=slight chance of being sleepy

2=moderate chance of being sleepy

3=high chance of being sleepy

_____ Sitting and Reading

_____ Watching TV

_____ Sitting in a inactive public place (meeting, theatre)

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ Sitting quietly after eating lunch without alcohol

_____ In a car while stopped for a few minutes in traffic