CHRISTOPHER M. SHAARI, M.D., P.C.
20 Prospect Ave, Suite 712
Hackensack, NJ 07601
PH: 201-342-8060, Fax: 201-546-1536
www.drshaari.com

Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____ Date of Birth _____ Age _____ Sex:_____

Address _____ Apt.#_____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

E-mail Address _____

Employer: _____

Race**:** ☐Asian ☐Black or African American ☐Native American or Alaska Native
☐Native Hawaiian or Other Pacific Islander ☐White / Caucasian ☐Other: _____

Ethnicity**:** Do you identify with an Ethnic origin? If yes, please note: _____

Primary Doctor _____

Who may we thank for referring you? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Name of Spouse/Parent/Legal Guardian _____ DOB _____

Emergency Contact: _____ Phone #: _____

Medical Insurance

Primary Insurance_____ Secondary Insurance (if any)_____
Primary Insurance ID:_____ Secondary Insurance ID_____
Patient is Subscriber/Policy Holder ☐Y ☐N Patient is Subscriber/Policy Holder ☐Y ☐N

Insured Information (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card
Subscriber/ Policy Holder: _____ Relationship to Patient: _____
Address: _____
Social Security Number: _____ Date of Birth: _____
Work Phone Number: _____ His or Her Employer: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Patient Name (PRINT): _____ *Date:*_____

Responsible Party Signature: _____ *Date:* _____

***If signed by someone other than the Patient**, state your name and relationship to the Patient and a description of your authority to act on the Patient's behalf:* _____

MEDICAL / SOCIAL HISTORY

What is the reason for your visit? _____

PHARMACY NAME (Address and/or Phone Number) _____

Allow Christopher M. Shaari, M.D., P.C. to obtain medication history via electronic means directly from insurer/pharmacy _____initial here

Medical Conditions: _____

Previous Surgeries: _____

Current Medications: _____

Medication Allergies: _____

Family Medical History:_____

Tobacco: Do you smoke? ☐Y ☐N If so, how many cigarettes/cigars per day? _____ Numbers of Years Smoking_____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week?_____

Drugs: Any history of illegal drug use? _____ If so, what types and how often?_____

REVIEW OF SYSTEMS: Please check "Yes" where applicable:

General health problems
Yes
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain

Eye problems
No Yes
- ☐ Double vision
- ☐ Itchy eyes
- ☐ Redness

Ear problems
Yes
- ☐ Drainage
- ☐ Hearing loss
- ☐ Infections
- ☐ Dizziness
- ☐ Itchiness
- ☐ Exposure to Excessive Noise
- ☐ Ear pain
- ☐ Ringing /noise in ears

Nose & Sinus problems
Yes
- ☐ Congestion
- ☐ Facial Pain
- ☐ Mouth Breathing
- ☐ Nose Bleeds
- ☐ Sneezing
- ☐ Runny Nose
- ☐ Post Nasal Drainage

Mouth & Throat problems
Yes
- ☐ Difficulty Swallowing
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Sores/Ulcers in Mouth

Heart or circulation problems
Yes
- ☐ Heart Murmur
- ☐ Chest pain
- ☐ Swelling of Ankles/Edema
- ☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems
Yes
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Musculoskeletal:
Yes
- ☐ Leg pain

Stomach problems
Yes
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Brain or Nervous system problems
Yes
- ☐ Headache
- ☐ Seizures
- ☐ Numbness

Glands & Hormone problems
Yes
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Blood or Lymph nodes problems
Yes
- ☐ Easy Bleeding
- ☐ Easy Bruising

Allergy problems
Yes
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Urticaria / Hives

Skin
Yes
- ☐ **I**tchy Skin/ Pruritis
- ☐ Rash
- ☐ Contact Allergy

Patient Name (PRINT): _____ *DOB*_____

Responsible Party Signature: _____ *Date:* _____

Notice of Privacy Practices

Dear Patient,

As required by privacy regulation mandated by HIPAA - Health Insurance Portability and Accountability Act, we are providing you with our Notice of Privacy Practices. We like to assure you we are fully committed to protecting your privacy. Please acknowledge receipt of Christopher M. Shaari, M.D., P.C.'s Notice of Privacy Practices by signing your name below.

I acknowledge receipt of Christopher M. Shaari, M.D., P.C.'s Notice of Privacy Practices.

Patient Name (PRINT): _____ *DOB*_____

Responsible Party Signature: _____ *Date:* _____

Patient Request for Confidential Communication

Christopher M. Shaari, M.D., P.C. may contact you by telephone at your home, work or cell unless you instruct us otherwise. Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obliged to honor it, except if any emergency arises.

I permit to be contacted as follows (check all that apply)

☐via Email: We may use your email to contact you.

☐At my HOME telephone number
☐Leave me a message with a call back number only

☐At my WORK telephone number
☐Leave me a message with a call back number only

☐At my CELL phone number
☐Leave me a message with a call back number only
☐On my cell via text message

☐Other : Please specify any other person {s) allowed to contact our office on your behalf:

_____

Patient Name (PRINT): _____ *DOB:* _____

Responsible Party Signature: _____ *Date:*_____

EMAIL COMMUNICATION OF HEALTH INFORMATION
FACT SHEET AND CONSENT FORM

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below,you agree to hold Christopher M. Shaari, M.D., P.C. harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Patient Email Address: _____

Patient Name (PRINT) _____ *Date:* _____

Patient Signature _____ *Date of Birth:* _____

CHRISTOPHER M. SHAARI, M.D., P.C.
20 PROSPECT AVE, SUITE 712, HACKENSACK, NJ 07601
Ph: 201-342-8060, Fax: 201-546-1536

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, deductibles and copayments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless other arrangements have been made in advance.

I authorize Christopher M. Shaari, M.D., P.C., to appeal to my insurance company on my behalf.

I hereby authorize Christopher M. Shaari, M.D., P.C. to furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information· concerning my illness and treatments. I hereby assign to Christopher M. Shaari, M.D., P.C. all payments for medical services rendered to myself or my dependents. I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me but the money paid by the insurance company belongs entirely to you. I, therefore, agree to immediately, but certainly no later than 5 days upon receipt of any such monies, endorse this check and forward this money directly to Christopher M. Shaari, M.D., P.C.. I will make no attempt to negotiate what portion I send to you.

I hereby further assign to Christopher M. Shaari, M.D., P.C. all of my rights under my insurance contract, including all of my rights governed by the statues and regulations of the Employee Retirement Income Security Act (ERISA), including, without any limitation whatsoever, my rights to "recover benefits" under ERISA Section 502(a)(1)(B), my rights to recover civil statutory penalties under ERISA Section 502(c)(1)(B); and my rights to pursue breach of fiduciary claims under ERISA Sections 502(a)(2) and 502(a)(3).

I understand that I am responsible for co-payment, deductible or for any amount not covered by my insurance. If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.33% of the unpaid balance. These costs are above and beyond any balance for services rendered.

Patient Name (PRINT): _____ *DOB*_____

Responsible Party Signature: _____ *Date:* _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.
Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form. When the provider you are scheduled to see does not participate with your insurance, your plan may not cover out-of-network services, leaving you to pay the full cost. If your plan does cover out-of-network services, you may be assessed a higher co-pay, deductible and co-insurance for out-of-network care. You will be responsible to pay these higher amounts plus any difference between the allowed amount and the amount the out-of-network provider charges for the service. Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Christopher M. Shaari, M.D., P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Christopher M. Shaari, M.D., P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Christopher M. Shaari, M.D., P.C. will not be involved with separation or divorce disputes.

  You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

  WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

  THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient Name (PRINT): _____ *DOB*_____

Responsible Party Signature: _____ *Date:* _____