M. ZAKIR SABRY, M.D., P.C.

Patient Information

Patient Name: _____ D.O.B:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip Code: _____

Telephone: Home:_____ Work:_____

Mobile: _____ E-Mail: _____

Would you accept promotions, and event notifications via e-mail ( ) Yes ( ) No?

Employer Name: _____ Telephone #: _____

Pharmacy: _____Telephone #:_____

Referred by: ( ) Friend:_____ ( ) Website: _____

( ) Other_____

Insurance Information:

Insurance name: _____ Policy #: _____ Group #:_____

Address:_____

Policy Holder:_____ SS#:_____

Relationship to Patient: _____ D.O.B._____

Assignments of Benefits

I hereby assign all surgical and/or medical benefits to which I am entitled, private insurance, Medicare, and any other health plans to M. Zakir Sabry, M.D. In consideration for services rendered, I hereby authorize payment directly to M. Zakir Sabry, M.D. the full amount due from my insurance carrier. I understand that I am financially responsible for all balances not covered by my insurance plan. I also understand that I will be wholly responsible and agree to pay any collection fees, which equal 1/3 of the total balance, plus any processing fee that might be incurred, to collect payment 1 full. This assignment will remain in effect until revoked by me in writing. A facsimile of this agreement is to be considered as valid as the original. I hereby authorize M. Zakir Sabry, M.D. to release any information necessary to secure assignment. I have received or reviewed the "Notice of Privacy Practices for Protected Health Information" as required by the Health Insurance Portability and Accountability Act of 1996, and acknowledge its posting and availability in the office for review.

_____ _____

Signature of Patient or Responsible Party Date