PATIENT INTAKE SHEET

Salma Khan, M.D.
35 Vicente Street
San Francisco, CA 94127
Tel: (415) 742-7444/Fax: (415) 692-8224
info@drsskhanmd.com

YOU MUST COMPLETE THIS FORM PRIOR TO YOUR FIRST CONSULTATION

***Please fax the completed form to* (415) 692-8224**

PATIENT INFORMATION

NAME: _____ SS#: _____

DATE OF BIRTH: _____/_____/_____ MARITAL STATUS: _____ SEX: MALE / FEMALE

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

AUTHORIZED METHODS OF COMMUNICATION

PRIMARY PHONE (WHERE OUR OFFICE CAN LEAVE A CONFIDENTIAL MESSAGE): _____

SECONDARY PHONE (WHERE OUR OFFICE CAN LEAVE A CONFIDENTIAL MESSAGE): _____

EMAIL ADDRESS: _____

INFORMED PATIENT CONSENT FOR ELECTRONIC COMMUNICATIONS

Unless authorized by the patient, Salma Khan, M.D. will use the minimum necessary amount of protected health information to respond to patient queries including those with minimal privacy–related consequences such as appointment reminders and notification of services.

☐ ***BY CHECKING THIS BOX, YOU HAVE MY CONSENT TO COMMUNICATE VIA EMAIL. I RECOGNIZE THAT EMAIL IS NOT A SECURE FORM OF COMMUNICATION AND THERE IS SOME RISK THAT ANY PROTECTED HEALTH INFORMATION THAT MAY BE CONTAINED IN SUCH EMAIL MAY BE DISCLOSED TO, OR INTERCEPTED BY UNAUTHORIZED THIRD PARTIES. USE OF EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION TO SALMA KHAN, M.D. INDICATES THAT I ACKNOWLEDGE AND ACCEPT THE POSSIBLE RISKS ASSOCIATED WITH SUCH COMMUNICATION.***

REASON FOR REQUESTING TREATMENT: _____

NAME OF CURRENT PSYCHIATRIST: _____ TEL#: _____

CURRENT MEDICATIONS: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

FINANCIAL RESPONSIBILITY

PARTY RESPONSIBLE FOR PAYMENT: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

_____ _____

Signature (If someone other than patient) Date

INSURANCE COMPANY: _____ TEL#: _____

SUBSCRIBER #:_____ GROUP #: _____

POLICY #:_____ CO-PAY AMOUNT PER VISIT: _____

DEDUCTIBLE ☐ YES ☐ NO AMOUNT: _____ EFFECTIVE DATE: _____/_____/_____

INSURANCE TYPE: MEDICARE / PPO / BC / BS / WC / ABMG / MVA / OTHER HMO

PRIOR AUTHORIZATION REQUIRED?: ☐ YES ☐ NO

PRIOR AUTHORIZATION#: _____

REFERRAL NAME/PHONE:_____

Note: You may require pre-authorization from your insurance company before they cover your treatment. Please call the authorization number on the back of your insurance card to have it authorized. Failure to do so may result in your incurring the full cost of your treatment.

POLICY HOLDER INFORMATION

INSURED PERSON_____ RELATION TO CLIENT:_____

ADDRESS_____CITY:_____STATE: _____ZIP:_____

DATE OF BIRTH: _____/_____/_____ EMPLOYER: _____

SECONDARY INSURANCE COMPANY INFORMATION

COMPANY:_____ PHONE_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

ID#_____POLICY#_____GROUP#_____

INSURANCE TYPE: MEDICARE / PPO / BC / BS / WC / ABMG / MVA / OTHER HMO

OFFICE POLICIES

DR. KHAN DOES NOT PRESCRIBE MEDICINES ON THE FIRST VISIT. **The first two appointments are for screening and/or consultation purposes only and are no guarantee of future sessions.**

DR. KHAN DOES NOT TREAT ATTENTION DEFICIT HYPERACTIVITY DISORDER.

DR. KHAN DOES NOT ACCEPT PATIENTS WHO ARE ACTIVELY USING ALCOHOL OR ILLICIT SUBSTANCES INCLUDING MARIJUANA.

Making Appointments:

Call (415) 742-7444 or email info@drskhanmd.com

The initial appointment is 45 minutes. Follow up appointments are 25 minutes.

Dr. Khan reserves the right to discharge any patient at any time for failure to comply with treatment recommendations, office policies, and/or failure to meet his or her financial obligations.

Rescheduling or Cancelling Appointments:

Call (415) 742-7444 or email info@drsskhanmd.com

Rescheduling appointments or cancellations must be made at least 5 days before your appointment date.

Rescheduling or canceling your appointment within 5 days of your scheduled appointment will result in a $100 charge and must be paid prior to your next appointment. Please note that this charge is not covered by your insurance company and will be billed to you directly.

Payment:

Payment in full is expected at time of service unless the provider is contracted with your insurance plan. **All co-pays are expected at time of service.** Payment arrangements will be considered on a case-by-case basis and are subject to management approval. **Failure to adhere to payment arrangements will result in your not being able to schedule and/or prescriptions not being filled.**

In the event that your account is not paid within 90 days and no arrangements have been made, your account will be turned over to a collection agency. In that event, you assume all costs of collection in addition to the account balance.

ASSIGNMENT AND RELEASE AND PERMISSION FOR TREATMENT

I hereby authorize a psychiatric evaluation and follow-up treatment be provided by Dr. Salma Khan, M.D.

I hereby direct payment to this office for psychiatric or medical benefits as authorized under the terms of my insurance policy. I authorize this office to release any information it acquires in the course of my evaluation or treatment to my insurance carrier(s) should it be requested. I hereby authorize photocopies of this form to be valid as the original. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment.

By signing my name below, I certify that the information provided within this health questioner form is accurate to the best of my knowledge. I understand this form is meant to assist the doctor in addressing / answering any questions or concerns that I may have. I also acknowledge I am responsible for informing my doctor of any health conditions or change(s) in my present condition.

Name (Print) Signature Date