THE NADERI CENTER

297 Herndon Pkwy, Suite 101, Herndon, VA 20170 703.481.0002
5454 Wisconsin Ave, Suite 1655, Chevy Chase, MD 20815 301.222.2020

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes _____ **E-mail** _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male ❒Transgender

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand purely cosmetic consultations are $100 (effective 7/1/2011) payable in advance by credit card at the time of scheduling. This fee is non-refundable if I do not reschedule or cancel my appointment with at least 24 hours notice prior to my appointment time. Functional consultation fees will be billed to me &/or my insurance company. I understand that office visit charges are payable in full on the same day service is rendered. All payments for surgery are due at least 2 weeks in advance of surgery. If insurance can pay for part of my desired surgery then my insurance may be charged for the office visit(s). I understand that my contract is between The Naderi Center and myself and it is my responsibility to follow through with my insurance. I authorize The Naderi Center to bill my insurance company when appropriate. Regardless of insurance coverage, **I am responsible for all bills being paid in full in a timely manner**. I understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.5% per month (18% per annum), and all court costs. I understand I will not dispute any charges on my credit card for services or product rendered at The Naderi Center. If a dispute arises, I waive my HIPPA rights. I also understand, I am free to review my doctor online but if I choose to share my experience on the web then out of fairness I voluntarily waive my HIPAA privacy rights in order for my doctor to be able to post replies &/or photos in the discussion _____ _____

Signature _____ **Date** _____

E-mail _____

Please make sure the information and spelling is completely accurate. It is your responsibility to keep this information up to date and inform us of any changes in the future.

THE NADERI CENTER CANCELLATION / RESCHEDULING POLICY

At The Naderi Center, we are dedicated to setting aside appropriate time to meet all of your needs and answer all of your questions. We ask in return that you provide the office with at least **24 hours** courtesy notice in the case that you need to cancel or reschedule your appointment.

Our cosmetic consult fee is normally $100 (Effective 7/1/2011). This fee is payable in advance by credit card at the time of your scheduling. This fee will be non-refundable if you reschedule or cancel your appointment with less than 24 hours notice. We thank you for your understanding.

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

SIGNATURE:_____

Print Name:_____