

ISAM A. HADDADIN M.D., F.A.C.S.

3641 Ridge Road
Highland, IN 46322

Ph # 219.923.2100

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Patient's Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Ph: _____ / Cell Phone: _____ SS# : _____ Marital Status: _____

Employer: _____ Work Ph: _____

Insurance: _____ ID #: _____ Grp #: _____

Spouse's Name (Parent's Name if a Minor): _____

Referred By: _____ Email: _____

How Did You Hear About Us – Please Specify: _____

PLEASE READ CAREFULLY AND SIGN

1. I request that payment of authorized Medicare/Insurance benefits are made to Dr. Isam A. Haddadin for any services furnished to me.
2. To **avoid any misunderstanding** regarding insurance, we wish our patients and clients to know that thou professional services rendered are billed to their insurance companies as a courtesy, they are still responsible. The patient is personally responsible for payment of these fees. **We do not** render services on the basis that the insurance company will pay for all these services, so it is the responsibility of the patient to pay the balance on paid services and the fees of all unpaid services. We will try to get authorization from the insurance company for all the services suggested for the treatment. Yet insurance companies may authorize part of or all or none of the suggested treatments needed. This process takes effort and time and your assistance is needed and helpful. Patients responsibilities would include: Deductibles, copays, and any unpaid services whether covered but not paid or not covered by the insurance. Example: Phlebectomies performed in office to cover for administration of medications, disposables and supplies.
3. I will be responsible for any fees incurred regarding the above named patient, and should this account become delinquent, and be necessary to refer to our collection agency; I will be responsible for any attorney or collection fees incurred in the recovery of this debt.
4. Due to incurred cost of scheduling surgical & laser procedures, we request that any cancellation or delaying of surgery will be communicated to our staff during business hours 8:00 to 4:30 Monday thru Friday. One week before scheduled date. Cancellation within 48 hours of scheduled time will cause a fee **\$250.00** charged to your account. I have read the above carefully and understand and sign to this agreement.
5. Also, I authorize Dr. Isam A. Haddadin to release my medical records and reports to my insurance company. I also authorize Dr. Haddadin to obtain my records from my health care providers. I hereby waive all privileges which attach to any communication of disclosures.

Signature of Patient or Responsible Party

Date