ISAM A. HADDADIN M.D., F.A.C.S.
3641 Ridge Road
Highland, IN 46322

Insurance Patient Form

Ph # 219.923.2100 **Fax # 219.923.2424**

Patient's Name: _____ Age: _____ Birthdate: _____

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

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

Employer: _____ Occupation: _____ Work Ph: _____

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

Insurance: _____ ID # _____ Grp # _____

Spouse's Name (Parent's name if minor): _____ Referred By: _____

Email # _____ How did you hear about us: _____

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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 for:
   - -all deductibles for the year
   - -copays required for all services
   - -all services unpaid for by insurance whether unauthorized or as may rarely happen for authorized services that insurance declines to pay for due to unsatisfactory reasoning.
3. Some insurance companies pay for physician fees as if done in the hospital. If done in the office, your insurance so far does not pay the differential for the office expense, like Medicare does. So unless these procedures are done in the hospital, patient will be responsible for $250-$300 for office costs to cover for **administration of medications, disposables and supplies**.
4. 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.
5. We understand that occasionally things happen and scheduled procedure may need to be postponed. We request kindly that for such change to inform the staff 48 hours ahead during business hours of 8:00 am-4:30 pm to be able to assign the time for other patients.
6. 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 healthcare providers. I hereby waive all privileges which attach to any communication of disclosures.

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Signature of Patient or Responsible Party Date