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

Medicare 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. HCFA has issued regulations that some services provided to **Medicare Beneficiaries** may be determined either non-covered or medically necessary and will not be paid for by Medicare. Because of this new ruling from HCFA, we must request that you authorize the performance of such service that we both agreed upon their necessity, and agree to pay for such services even if Medicare later determines them to be non-covered or unnecessary.

   _____ **Supplies, Medications, and Disposables (e.g. certain items that are needed beyond simple daily care of routine such as stockings, specialty bandages, and medications)**

   _____ Medicare does not usually pay for frequent treatments.

   _____ Medicare does not pay for this service for the reported condition.

3. 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.
4. Also, I authorize Dr. Isam A. Haddadin to release my medical records, or to obtain records including lab reports, EKG, X-rays or any information that is part of my medical records to my insurance company or from my health care providers. I hereby waive all privileges which attach to any communication of disclosures.

_____

Signature of Patient or Responsible Party Date