Lifetime Family Healthcare

Iram Shaikh-Abbasi, M.D.

4 Walker Avenue, Ste B, Clarendon Hills, IL 60514

Phone: 630 468 2034

Fax: 866 242 0565

Thank you for choosing Lifetime Family Healthcare for your medical needs. Included below are new patient forms. Please print and complete these forms and bring them to your visit. Please also bring your ID and insurance cards.

If you take any medications, please provide a list of dosages and/or bring the bottles with you to your appointment. Plan to arrive at least fifteen minutes before your appointment.

Please give us a 24 hr notice if you need to cancel or reschedule an appointment.

There is a $50 charge for No shows or late cancellations.

We look forward to meeting with you.

Sincerely,

The Staff at Lifetime Family Healthcare

Lifetime Family Healthcare

PATIENT INFORMATION

Name:_____ DOB:_____

Sex: _____ Race: _____ Ethnicity:_____

Marital Status: _____

Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____

Home Phone:_____

Email:_____

Emergency Contact: _____Phone:_____

Pharmacy Name/ Address & Number:

_____

How did you hear about us?_____

Lifetime Family Healthcare

INSURANCE INFORMATION

I, the undersigned, herby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned and personally signed the particular claim.

I, _____ hereby authorize _____ to pay and hereby assign
(Name of Insured) (Name of Insurance Company)

directly to Lifetime Family Healthcare LTD all benefits, if any, otherwise payable to me

for their services as described on the attached forms. I understand I am financially responsible

for charges incurred. I further acknowledge that any insurance benefits, when received by and

paid to Lifetime Family Healthcare LTD will be credited to my account, in accordance with the

above said agreement.

Authorized Signature of Subscriber _____

Date:_____

PERMISSION TO RELEASE MEDICAL INFORMATION

According to HIPPA regulations for your privacy in Illinois, our office is only allowed to give your medical information to you. If you would like to authorize anyone else to have access to your information, please list their names below:

NAME: RELATIONSHIP:

_____

_____

_____

Lifetime Family Healthcare

4 Walker Avenue, Ste B, Clarendon Hills, IL 60514

Tel: (630) 468 2034

Fax: (866) 242 0565

I acknowledge receipt of Lifetime Family Healthcare's notice of privacy policy.

Do you consent to exchange of data with other physicians, that care for you or have cared for you, connected through our interoperability hub.

Yes_____ No_____

Signed:_____

Relationship to patient:_____

Date:_____

Lifetime Family Healthcare

RELEASE OF CONFIDENTIAL HEALTH INFORMATION:

I , Name:_____DOB: _____, hereby authorize

Practice Name:_____

Phone Number:_____

to release my medical record to Lifetime Family Healthcare: Iram Shaikh-Abbasi, MD

4 Walker Avenue, Ste B, Clarendon Hills, IL 60514.

Tel: 630 468 2034 Fax: 866 242 0565

( ) The entire medical record, excluding mental health treatment, alcoholism treatment,

& HIV/AIDS records

( )Mental health records

( ) Alcoholism treatment records

( ) HIV/AIDs records

( ) Other

I also allow Lifetime Family Healthcare to access my records

Sign: _____

Date: _____

Lifetime Family Healthcare

Appointment Cancellation Policy Agreement:

Lifetime Family Healthcare is committed to providing exceptional care.
We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. However, we require patients to cancel appointments 24 hours prior to a scheduled visit. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.
Please call us 24 hours prior to your scheduled appointment to reschedule.

If prior notification is not given, you will be charged $ 50.00 for the missed appointment.
This fee will be billed directly to you and not to your insurance.

Please sign below to consent to these terms.

_____
Patient Signature (Patient's Parent/Guardian if under 18)

_____
Date