

**GHASSAN N. FANOUS, M.D.**

540 West 5th Street, Suite 420 Odessa, Texas 79761  
(432) 582-2280

**REGISTRATION FORM**

**PLEASE PRINT CLEARLY**

Date \_\_\_\_\_

Referred By \_\_\_\_\_

Pharmacy Preference \_\_\_\_\_

Reason For Visit \_\_\_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Driver's License No. \_\_\_\_\_ D.L. State \_\_\_\_\_ Marital Status: (please circle) Single - Married - Other

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Can we contact you your place of employment? \_\_\_\_ YES \_\_\_\_ NO

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Relation to Insured \_\_\_\_\_

Insured Full Name \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Emergency Contact\* \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION / PAY FOR SERVICES I hereby authorize Ghassan Fanous, M.D. to release any information required in the course of my examination or treatment. I hereby authorize payment directly to the business office of Ghassan Fanous, M.D. for the surgical and or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS  
TO OR FROM MEDICAL PROVIDERS**

I hereby authorize Dr. Fanous to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize Dr. Fanous to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize Dr. Fanous to release any and all medical records concerning my care to Medicare, Medicaid and Insurance Company, Third Party Administrator, or Managed Care Company.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Social Security Number

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
INDIVIDUALS / FAMILY MEMBER**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Dr. Fanous or staff to discuss your condition with members of your family or other individuals that you designate, we must obtain authorization due to the severity of your medical condition, the law stipulated that these rules may be waived.

\_\_\_ I **do not** authorize Dr. Fanous to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_ I **authorize** Dr. Fanous to verbally release any or all information concerning my medical care to the following individuals:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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**IF YOU HAVE INSURANCE READ AND SIGN**

**PRIVATE INSURANCE ONLY**

I have informed Dr. Fanous' office staff that I only have private insurance, and that I have no other form of coverage. I understand that if I have any other coverage, or changes, it is my responsibility to notify the office.

**This office will not file retro Medicaid.**

Dr. Fanous will only file Medicaid two (2) weeks prior to the run date on the card I present. Any balance remaining, prior to that time, is my responsibility.

\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Date

**IF YOU HAVE NO INSURANCE READ AND SIGN**

**PRIVATE PAY PATIENTS**

I understand that Dr. Fanous is accepting me as a private pay patient. I will be responsible for any services I receive, and his office will not file a claim to Medicaid for services provided to me. Payment will be due at time of service, unless prior arrangements have been made with the office manager.

\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Date

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I understand that I have been accepted by Ghassan Fanous, M.D. as an insured or self pay patient. Dr. Fanous will NOT accept Medicaid as secondary to any private or commercial insurance nor will he accept Medicaid retroactively. I understand that by signing this waiver that I will be responsible for my deductible, co-pays, and any amount not covered by my insurance.

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Patient Signature

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Witness Signature

---

Date

**GHASSAN N. FANOUS, M.D.**

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**Acknowledgement of Receipt of Notice of Privacy Practices**

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPPA). Providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was reviewed.

Therefore, I \_\_\_\_\_ (printed name of patient or personal representative) acknowledge that **GHASSAN N. FANOUS, M.D.** has provided a written copy of the Notice of Privacy for Protected Health Information to myself or \_\_\_\_\_ (specify if signing as a personal representative, documentation of your legal right to do so must be provided.)

\_\_\_\_\_  
Signature of Patient / Representative

\_\_\_\_\_  
Date

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**TO BE COMPLETED BY GHASSAN FANOUS, M.D. OR STAFF MEMBER**

We made a good faith attempt to provide the above named patient with a copy of Our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date