ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Please read and complete the entire form.

Last Name _____First_____ MI __ Date of Birth_____ SS#_____

Address _____ City _____State_____ Zip_____

Northern Address _____ City _____ State _____ Zip_____

Home phone # _____Cell # _____Northern Ph # _____

Circle which phone number should be your PRIMARY contact number>>> Home Cell Work

Employer_____ Employer Phone _____

Email Address _____ May we email regarding cosmetic services we offer? Yes No

Primary Insurance Co: _____ Policy Holder _____ And DOB _____

Secondary Insurance Co: _____ Policy Holder _____ And DOB _____

SS# Primary Policy Holder: _____SS# Secondary Policy Holder: _____

Emergency Contact: _____ Telephone: _____

Authorization for Direct Payment & Release of Information via Auto-Fax

I authorize release of information to my insurance companies, and any holder of Medicare and/or other insurance companies to support reimbursement for services rendered at Surgical Associates of Venice & Englewood. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the provider or facility furnishing the services. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies. I authorize Surgical Associates of Venice & Englewood to release information from my medical record to my referring physician, primary care physician, and other provider involved in my treatment for the purpose of continued care.

Financial Agreement

I understand that I am fully responsible, upon receipt of services or billing invoice, for any charges incurred by me for professional services rendered by the providers at Surgical Associates of Venice & Englewood. I understand that I may be required to make a payment at the time of any visit, if an insurance co-payment or deductible payment is required. I will be required to make payment on any past due balances on my account. I understand that if Surgical Associates of Venice & Englewood should file a claim with my medical insurance and/or third party representative, it is for my convenience and does not constitute any guarantee of payment by insurance or representative. If care is required and my insurance plan or contract determines the treatment is a non-covered service, and if the plan refuses payment to the provider, I understand I am responsible for full payment of services prior to, or at, the time of services rendered. I understand that, should the charges incurred be the result of an injury involving a third party and I have involved an attorney for purposes of a liability claim against the third party, I am responsible for all charges at the time services are rendered and not at the time of any liability settlement.

My signature below indicates I have read, understand and agree with the information disclosed in this document. I have also been offered, or received a copy of the Notice of Privacy Practices provided by Issam A. Halaby, M.D. PhD FACS

Patient Acknowledgement _____ ***Date*** _____