



Ahmed Khan, MD, CAQSM
 25 Hidden Ravines Drive
 Powell, OH, 43065
 Telephone 614-636-2378
 Fax 614-413-3520
 Email info@columbusportsmd.com
 www.columbusportsmd.com

PATIENT INFORMATION

Today's Date _____

Last Name: _____ First Name _____ Middle _____
 Mailing Address _____
 City: _____ State: _____ Zip Code _____
 Date of Birth _____ Home Phone: _____ Work Phone _____ Cell Phone _____
 Email Address: _____ Sex: Male ___ Female ___ Marital Status _____
 Primary Care Physician: _____ List Physician(s) seen for problem seeing us for today(i.e. Surgeon, Pain Management, Chiropractor, Physical Therapy, etc _____

How did you hear about us?

REFERRAL INFORMATION:

Person to contact in case of emergency: _____ Phone: _____
 To better serve our patients, we will automatically fax all prescriptions to the pharmacy for you:
 Pharmacy: _____ Phone: _____ Fax _____
 Pharmacy Location _____

AUTHORIZATION AND FINANCIAL POLICY

I, the undersigned, certify that I (or my dependent) assign directly to CCSRM/Ahmed Khan, M.D., all insurance benefits for services rendered. Medicare and/or other insurance carriers will only pay for services that it determines to be "reasonable and necessary." If my insurance company determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under my policy with my insurance carrier, they may deny payment for these services and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. My signature below shows that I understand that all copayments, coinsurance, deductibles, non-par insurance and self pay are due at the time services are rendered. I understand that CCSRM/Ahmed Khan, M.D. has the right to charge me \$35 for any returned check and \$50 for any office appointments and \$150 for any procedures I fail to reschedule (No-Show Appointments).

CANCELLATION FEE POLICY-My signature below shows that I understand the cancellation policy: \$95 Fee for less than 24 hours notice of cancellation for consult and follow up office visits or not showing for the appointment. \$200 Fee for less than 7 days notice for scheduled procedures or not showing for the appointment. I also understand that payment of these fees must be made prior to any future appointments being scheduled.

I, the undersigned, certify that I (or my dependent) understand that **All PRP deposits are non-refundable.**

For HIPAA Compliance, please answer the following questions:

I authorize you to leave appointment messages or send information to me via:
 ___ Answering Machine ___ With another person ___ Mail ___ Email

My signature below also indicates that I have been provided, CCSRM/Ahmed Khan, M.D.'s Notice of Privacy Practices.

My signature below authorizes CCSRM/Ahmed Khan, M.D., general consent for evaluation, treatment and the understanding of CCSRM/Ahmed Khan, M.D. Financial and Cancellation Policy.

Signed: _____ Date: _____
 Patient or person authorized to consent signature

If Guardian, state relation: _____

I give CCSRM/Ahmed Khan, M.D., permission to release medical information to the above referring and/or Primary Care Physician

Signed: _____ Date: _____

We gladly accept Cash, Checks, MC, VISA, AMEX, DISCOVER.