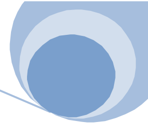


Niaz Medical Services, P.C.

104-14 113th Street PH: (718) 835-2254
South Richmond Hill, NY,1419-2506 Fax: (718) 835-9111

78-40 Parsons Blvd., PH: (718) 612-9799
Flushing, NY,11366-1930 Fax: (718) 835-9111

208 E 116th Street PH: (212) 203-4444
New York, NY,10029-1451 Fax: (212) 203-4444

Patient Information

Last name:_________________________**First name**: _______________________ **MI**: _____

Birth date:________________________(mm/dd /yyyy) **Sex:** Male ☐ Female ☐

Address: ____
Home Tel #: _______________________________
Mother/Guardian Name:______________________________ **Cell #**______________________
Father Name:_______________________________________**Cell #**______________________

Race: ☐ **Asian** ☐ **Black/African American** ☐ **Native** ☐ **Hawaiian/Pacific Island**

☐ **White** ☐ **Other Race** **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

Language: _____________________________ **E-mail** ____

PROVIDE PHARMACY NAME AND ADDRESS____

Insurance Information

Person Responsible for account:
Last Name:____________________________**First Name:**_________________________**M.I:**____
Relation to patient:_________________**Birth date:**________________**Soc. Sec. #:**______________
Primary Insurance:_________________________________**Subscriber #**______________________
Group # ____________________ **Medicaid #**_______________________________________
Additional Insurance: ____

Assignment and Release

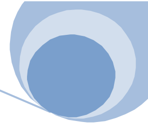
I certify that I, and/or my dependent(s), have insurance coverage with_________________________________and assign directly ***Dr. Sameera Haroon*** all insurance benefits, if any, otherwise payable tome for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to above named Insurance Company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature Representative ______________________ Name of Representative_________________________

Date _________________________

PLEASE VISIT US ON OUR WEBSITE WWW.NIAZMED.COM AND ASK US ABOUT YOUR OWN PATIENT PORTEL TODAY!



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New York, NY,10029-1451 Fax: (212) 203-4444

Patient Name: ________________________

DOB:_____/_____/__________

Notice of Privacy Practices

By signing this form, you acknowledge that you have received/or read from the wall the privacy practices for Niaz Medical Services, P.C. Which describe Niaz Medical Services, P.C. use and disclosure of your or your child individually identifiable health information for treatment.
Patient is:______Minor ______Unable
Signature of representative: ______________________________________
Name of representative (print) ______________________________________
Relationship to patient________________________Date ___________________________

Patient Notification Policy

In compliance with the federal HIPPA Statute, it is our policy to release patient information other than to the patient or person authorized by the patient. Therefore other than an appointment reminder or cancellation no other information will be left on an answering machine, voice mail, text message or e-mail.
If you prefer that we do communicate confidential information other than to yourself, please complete the following and sign.

I authorize Niaz Medical Services, PC to communicate medical information pertaining to my care by the following method.

Answering Machine: (_____) ______________
Voice Mail: (_____) _____________________
Text Message: (_____) ___________________
E-mail: ________________________________

Sign __________________________________ Date_____________________________

Optional

Authorization for Medical Treatment without Parental Presence for Adolescent

I,______________________________, mother/father/legal guardian of____________________________(child's name), D.O.B_____/_____/_____. Allow Dr. Haroon to examine, give treatment, immunization; do blood test, etc., without my presence.

Sign ___________________________________ Date ________________________________

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