# Iqbal Saeed, M.D., L.L.C.

**2227 Drake Avenue, Suite 7A • Huntsville, Alabama 35805**

Date _____

## Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ Cell Phone _____
include area code include area code

Sex _____ Birth Date _____ Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____
mm/dd/yyyy

Race _____ Preferred Language _____ Ethnicity _____

Patient's Employer _____ Occupation _____ Work Phone _____
include area code

Spouse's Name _____
Last Name First Name Middle Name Name you go by

Spouse's Employer _____ Occupation _____ Work Phone _____
include area code

How did you find out about our practice? _____

## Emergency Contact

Contact's Name _____ Relationship _____ Phone _____
include area code

## Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

## Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I agree to assume responsibility for payment of charges if my balance is not covered by my healthcare provider.

Signature: _____ Date: _____

I hereby authorize Iqbal Saeed, M.D. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Iqbal Saeed, M.D. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature: _____ Date: _____

## No Show Policy

If you do not call the office within 24 hours of your appointment to cancel or reschedule your appointment you may be charged a $25.00 no show fee that will not be paid by your insurance company. The payment will be due when you come in for your next office appointment. After 3 no show appointments you may be discharged from the practice for non-compliance.

Signature: _____ Date: _____

## Appointment Reminder

I agree, in order for us to service your account or to collect monies you may owe, Iqbal Saeed, MD, LLC and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/atrificial voice messages and/or use of automatic dialing devices, as applicable.

Signature: _____ Date: _____