

# Northwest General & Colon-Rectal Surgery, P.A.

Khawaja Azimuddin, MD, FACS, FASCRS

Junuk Kim MD

## Personal Information

Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_  
Street City State Zip Code

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: \_\_\_\_\_

DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Pharmacy name: \_\_\_\_\_

Pharmacy Tel: \_\_\_\_\_ Pharmacy address: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip Code Work phone

In case of emergency who should be notified? \_\_\_\_\_  
Name Phone

## Insurance Information

Primary Insurance Company: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

## Guarantor Information

Person responsible for account: \_\_\_\_\_ Relationship to Pt.: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Khawaja Azimuddin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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

\_\_\_\_\_  
Printed Name of Patient/Guardian

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

**NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A.**

**KHAWAJA AZIMUDDIN M.D.  
JUNUK KIM M.D.**

**Consent for treatment:** I acknowledge that I am responsible for following my physician's recommendations and to do what is necessary to control and treat my condition.

I understand that the sole responsibility of my health and well being is in my hands in view of the above and that I cannot reasonably hold my physician responsible if I do not adhere to his recommendations and/or not take medications as I am instructed to do so.

**Declaration of financial responsibility:** I am responsible for payment. If for any reason my insurance company does not pay the charges at Northwest General & Colon-Rectal Surgery, P.A. I will be liable for all unpaid balances. I understand that in an effort to expedite my care and to provide me with better service, the doctors may choose to perform my operation in a facility where they may have ownership interests. This in no form or shape will affect the medical care provided to me. I also understand that I have the option to choose an alternative location for my medical care, if I so choose to.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**[www.ColonSurgeonHouston.com](http://www.ColonSurgeonHouston.com)**

## **HIPAA NOTICE OF PRIVACY PRACTICES**

I am aware of the HIPAA Notice of Privacy practices for Northwest General & Colon Rectal Surgery and the copies of the notice are available for me to take upon request.

### **Authorization to release protected health information to designated persons:**

I give my authorization to release medical/surgical information to the following designated representatives:

- My Spouse (Name): \_\_\_\_\_
- My Children (Names): \_\_\_\_\_
- Other (Name): \_\_\_\_\_
- May not be given to anyone other than myself

### **I hereby authorize medical information to be relayed to me via phone / email:**

### **Acknowledgment of receipt of privacy practices:**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature