Sally Habib, MD, LLC. 120 Sister Pierre, Suite 306, Towson, MD 21204

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME:_____ MI_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ AGE: _____

HOME PHONE : _____CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

NAME/ADDRESS OF RESPONSIBLE PARTY IF DIFFERENT FROM YOURS:

_____

_____

Do we have your permission to leave non-urgent messages on your voice mail? : YES NO
Which numbers may we leave messages on? HOME CELL WORK

EMERGENCY CONTACT:
Name:_____ Relationship:_____

Phone number: _____

I have received/reviewed a copy of the HIPAA privacy notice: _____(initials)

I understand that I will be charged $25 for appointments cancelled without 24 hours notice:_____ (initials)

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE _____ (initials)

I UNDERSTAND THAT DR.HABIB DOES NOT PARTICIPATE WITH MEDICARE OR ANY OTHER INSURANCE PLAN _____ (initials)

SIGNATURE: _____ DATE: _____