

**SunState Medical Associates, P.A.**

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**FARIDEH A. ZADEH, M.D.**

Board Certified Internal Medicine

**ZIA FATEMI, M.D.**

Board Certified Internal Medicine

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Board Certified Internal Medicine

**PATIENT INFORMATION - PLEASE PRINT**

PATIENT NAME \_\_\_\_\_  
First MI Last

MAILING ADDRESS \_\_\_\_\_  
# and Street City State Zip

LEGAL ADDRESS \_\_\_\_\_  
(If Different) # and Street City State Zip

SS # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_  
(State)

PHONE # (\_\_\_\_) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ARE YOU EMPLOYED \_\_\_\_\_ STUDENT \_\_\_\_\_  
Full Time Part Time Full Time Part Time

PATIENT'S EMPLOYER \_\_\_\_\_ PATIENT'S EMPLOYER'S  
PHONE # (\_\_\_\_) \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_ PATIENT'S EMPLOYER'S  
ADDRESS \_\_\_\_\_

REFERRING OR FORMER PHYSICIAN(S) NAME, ADDRESS AND PHONE NUMBER:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_  
(OR GUARDIAN) FIRST MI LAST

BIRTH DATE OF SPOUSE \_\_\_\_\_ SPOUSE'S  
(OR INSURED) SS # \_\_\_\_\_  
(OR INSURED)

SPOUSE'S EMPLOYER \_\_\_\_\_ SPOUSE'S EMPLOYER'S  
(OR INSURED'S EMPLOYER) PHONE # (\_\_\_\_) \_\_\_\_\_  
(OR INSURED'S EMPLOYER'S NUMBER)

PERSON TO NOTIFY IN CASE OF EMERGENCY: RELATIONSHIP TO PATIENT:  
\_\_\_\_\_  
ADDRESS and PHONE NUMBER: \_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
(Policyholder) (Policyholder)

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
(Policyholder)

Relationship to the patient: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
(Policyholder) (Policyholder)

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
(Policyholder)

Relationship to the patient: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

**SUNSTATE MEDICAL ASSOCIATES, PA  
FINANCIAL POLICY**

Thank you for choosing our practice as your health care provider. SunState Medical Associates is committed to providing our patients with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

The following is a statement of our financial policy which we require you to read and sign before any medical treatment.

- All patients must complete our information and insurance forms.
- Full payment and/or co-payments are due at the time of service.
- We accept cash, checks, Visa or MasterCard.
- Returned checks are subject to a \$29.00 service charge.
- Referrals are processed within 3-5 business days, **UPON DOCTOR'S APPROVAL.**
- Prescription refills require 72 hours notification, **UPON DOCTOR'S APPROVAL.**
- **No-Show charge of \$25.00 for missed appointments will be charged unless cancelled at least 24 hours in advance.**

**HEALTH INSURANCE PLAN OBLIGATION**

SunState Medical Associates, P.A. maintains a list of healthcare service plans which are contracted to provide professional medical services. We have agreed to bill those insurance carriers for all services rendered. Authorization from your insurance does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments and deductibles. If your insurance company has not responded to our claims submittal within 60 days, payment for services incurred and claim status follow-up with the insurance carrier becomes the patient's responsibility.

**NON-PARTICIPATING INSURANCE**

All fees are due in full at the time of service. A receipt is provided which details all medical service and payments for the office visit. A copy of the receipt can be submitted to your insurance carrier for direct payment to you, the policyholder.

**PPO/HMO/MANAGED CARE/MEDICARE/MEDICAID/TRADITIONAL INSURANCE WAIVER REGARDING NON COVERED PATIENTS**

Medicare under section 1862 (A) (1) of the Medicare law and some health insurance carrier determines that a particular service or services were not authorized, or not a covered benefit under your plan, Medicare and/or other insurance plans will deny payment for these services. We believe that according to your insurance/Medicare plan, payment is often denied for the following services:

- Copies of medical records directly to patient
- Well Woman Exams
- Certain lab tests
- Physicals
- Out of network referrals
- Pre-existing conditions
- Work-in appointment

Should collections become necessary, the patient will be responsible for all collection costs and attorney's fees. Please let us know if you have any questions or concerns.

I have read the financial policy of SunState Medical Associates, P.A. I understand and agree to the above statement.

X \_\_\_\_\_  
Signature Of Patient

\_\_\_\_\_  
And/Or Responsible Party

\_\_\_\_\_  
Please Print Your Name

\_\_\_\_\_  
Date