The Samra Group, LLC
Pediatrics & Adolescent Medicine

300 Perrine Road Suite 331
Old Bridge, NJ 08857
(732) 727-8800

733 North Beers Street Suite L5
Holmdel, NJ 07733
(732) 727-8800

Patient's name_____ Date of Birth__/___/____

Age _____ SS #_____ Sex: Male ☐ Female ☐

Address_____City_____State____Zip_____

Home Number: _____ Cell Number: _____

Medication Currently Taking _____ Allergies_____

PHARMACY NAME & ZIP CODE _____

Father/Guardian's Name _____ DOB: _____SS #_____

Father/Guardian Employer_____Work/Cell #_____

Mother/Guardian's Name_____ DOB: _____SS#_____

Mother/Guardian Employer _____Work/Cell #_____

****

Siblings (please list last name) _____

_____

****

Medical Insurance_____

Subscriber_____ Relationship to Patient: _____

I authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to The Samra Group the insurance benefit otherwise payable to me. I understand I'm financially responsible to the doctor for charges not covered by this assignment. I understand the balances for which I am responsible are subject to interest charge if payments are delinquent (1.5% per month). There will be 35% interest charge in the event your account is turned over to a collection agency.

Authorization for Disclosure of information:
I hereby authorize The Samra Group to disclose complete information concerning his/her medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Barakat's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Signature of Patient/Subscriber_____ Date_____

Please make all checks Payable to The Samra Group

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I.D.#_____ Group #:_____

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Patient Consent for the use and Disclosure of Protected Health Information

With my consent, The Samra Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Samra Group's Notice of Privacy Practices foe a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Samra Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

The Samra Group Privacy Officer
733 North Beers Street Suite L5
Holmdel, N.J. 07733

With my consent, The Samra Group may mail to my home or other designated location and leave a voicemail message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, The Samra Group may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as a appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request The Samra Group to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Samra Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Samra Group may decline to provide treatment.

Signature of Parent/ Legal Guardian: _____

Patient Name: _____Date:_____

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Patient's Name: _____

Date of Birth: _____

Today's Date: _____

I, _____ (Parent/Guardian), give permission for The Samra Group to administer all appropriate immunizations to my child.

Signature: _____

FOR PATIENTS WITH PRIVATE INSURANCES ONLY: I am aware that my insurance company may/ may not cover the following injections:

- Pediarix (DTAP, IPV, HEP B)
- Menactra
- Tdap
- Varivax
- Hepatitis A
- Gardasil (HPV)

I understand that I am responsible for any charges my insurance company does not cover.

Parent/Guardian Signature: _____Date:_____

Witness Signature (Office Staff): _____

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Patient Protected Health Information Disclosure Authorization

Please provide us with a list of relatives and/or friends in which you would like us to be able to release information to.

1.) Name: _____ **Relationship:** _____

2.) Name: _____ **Relationship:** _____

3.) Name: _____ **Relationship:** _____

4.) Name: _____ **Relationship:** _____

5.) Name: _____ **Relationship:** _____

Listed above are the name of relatives and/or friends in which the physicians and staff of The Samra Group have my permission to disclose and discuss my child's protected health information that is related to my past, present, and/or future physical or mental health condition and related healthcare services. I understand that this authorization will remain in effect until a written request is submitted stating otherwise.

Patient Name: _____**Date of Birth:** _____

Parent/ Legal Guardian's Signature: _____

Date: _____

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Please let us know how you were referred to our office.

Patient referral: If so, please tell us their name so we may thank them.

_____

Advertising: If so, please tell us where.

_____

Other:

_____

Thank you.

PI-3/08

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UPDATE FORM
(FOR NEW AND EXISTING PATIENTS)

Patient Name: _____DOB: _____

Parent's E-mail Address: _____@_____

As a part of the government incentive program for electronic health records, we kindly ask that you provide us with the following information:

Race (i.e. Black/African American, Caucasian, Asian, etc.): _____

Ethnicity (i.e. Latino, Hispanic, German, Egyptian, etc.): _____

Preferred Language: _____

Current or Past Medical History:

☐Heart disease
☐High blood pressure
☐High cholesterol
☐Low blood pressure
☐Anemia/Blood disorder
☐Seasonal allergies
☐Asthma
☐Shortness of breath
☐Seizure
☐Headaches/Migraines
☐Neurological disorder
☐Anxiety/Depression
☐Psychiatric care
☐Diabetes
☐Kidney/Bladder/Liver disorder
☐Thyroid disorder
☐Other: _____

Social and Preventative History (13 years and older) :

Does the patient currently smoke or chew tobacco? ☐Yes ☐No

If not, did he/she do so in the past? ☐Yes ☐No

Signature: _____**Date:** _____