H.Jabbour, M.D
Vitlink Psychiatric Services PLLC
8380 Six Forks Road. Suite 101
Raleigh, NC. 27615
Phone (844) 872-8621 Fax (855) 443-877

Patient Registration

Referred by ______________________________

Patient First Name _______________________ Middle___________ Last_________________________________
Age_______ Date of Birth _______________ Gender __________ Social Security # ___________________

Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Partnered [ ]
Home Address: _______________________________ City: _______________ State: ______ Zip Code: ________

Home Phone # _________________ Business Phone #__________________ Mobile Phone # _________________

Preferred telephone number for appointment confirmation ____

Employer _________________________________ Employer Address ____________________________________
City ___________________________________ State ___________ Zip Code _____________________________

Has any other family member been seen previously by Dr. Jabbour? ____ No ____ Yes
If yes, who and when ____

Emergency Contact

First Name _____________________ Last Name _________________________ Relationship ________________

Address ______________________________ City __________________ State ________ Zip Code ___________

Telephone Home # __________________ Work # __________________ Mobile # _________________________

Local Pharmacy Information

Name __________________________ Address _____________________________ Phone Number ______________

Mail Order Pharmacy

Name ___________________________ Mailing Address ____

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

____ _________________________
Signature Date

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Name ____ Date of Birth ___________

Mailing Address ____

City ____________________ State __________ Zip Code _____________

____

By signing this form, you grant Hassan Jabbour, MD (the Practice) and Hassan Jabbour, MD consent to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations as described in our Notice of Privacy Practices. Our Notice provides a description of our uses and disclosures regarding your protected health information and your health information rights.

With this consent, you are granting permission for Hassan Jabbour, MD to call your home, or other designated location and leave a message, in person or by voice mail, in reference to any items that assist the practice in carrying out your treatment, payment activities or healthcare operations. This may include, but not be limited to, appointment reminders, prescription information or any matters pertaining to your clinical care. This consent also allows for e-mail communication regarding appointments. You are also granting permission for us to talk with your designated emergency contact person when needed.

Hassan Jabbour, MD may not be able to agree with every special restriction request regarding use or disclosure of your protected healthcare information. However, if granted we are bound by such agreement.

Hassan Jabbour, MD reserves the right to revise our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain any changes.

Right to Revoke: You will have the right to revoke this Consent at any time, except to the extent that Hassan Jabbour, MD has already made disclosures in reliance upon prior consent. A refusal to sign this Consent or a revocation may result in refusal or discontinuation of treatment.

I have been provided an opportunity to review the Notice of Privacy Practices and I understand that I will be provided a copy, upon request, before signing this Consent.
Signature ____________________________________ Date ____________________

If, on behalf of the patient, a personal representative signs this Consent, please complete the following:

Representative's Name ___________________________ Relationship to Patient ____________________

Upon request you are entitled to a copy of this consent after you sign it.

The following statement is to be signed only if you decide to revoke your Consent agreed to by the signature above.

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand the revocation of my Consent will not affect any action taken in reliance on my consent before you received my written Notice of Revocation. I also understand that I may be declined treatment as a result of my Revocation of Consent.

Signature ____________________________________ Date ____________________