PATIENT INFORMATION (INFORMACION DEL PACIENTE)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

AUTHORIZATION TO PAY

Today's Date: _____

I hereby authorize _____ Insurance Company to pay by check made out and mailed directly to:

Schlomo Schmuel, D.P.M
Thomas D. Lim, D.P.M

2711 W. Sunset Blvd
Los Angeles, CA 90026

12125 Vanowen St. Ste#4
North Hollywood, CA 91605

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. The payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner any balance of said Professional Service charges over and above this insurance payment.

Name: _____

Address: _____

Signature: _____

HIPAA Consent Form

I understand that under the health Insurance Portability & accountability act of 1996 (HIPPA)., I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity to review such notice of Privacy Practices prior to signing this contract. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact the organization at any time at the address below to obtain a current copy of the notice of Privacy practice.

I understand that I may Request in Writing that you restrict how my private instruction is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such instructions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Signed- Patient Date/ Time

_____ _____

Witness/ Interpreter Date/ Time.