Patient Registration Form

lame (Last, First Init.)			Date of Birth	Age	Sex M F
\ddress		City		State	Zip Code
lome Phone #	Cellular Phone #		Phone number where we may leave medical information:		
;ocial Security #	Driver's Lic. #		E-mail Address		
)ccupation	Employer		Work Phone #		
lame of Spouse or Parent (for Children)					
)ccupation of Spouse	Spouse's Employer		Work Phone #		
:mergency Contact Name			Phone #		
lame of a Friend or Relative			Phone #		
Primary Insurance Holder's Info	Name	Date of Birth	Social Security #		
Referred By			Phone #		
'rimary Physician			Phone #		
)entist			Phone #		

Financial Policy

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to provide you with the best medical care service. The following nformation is intended to prevent uncertainties in regards to our financial policy. Our practice firmly believes that a good doctor-patient elationship is based upon understanding and good communications.

nsurance

Our practice accepts insurance from all major insurance companies. As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment, review your insurance form, and file your claim with your insurance carrier. You will be responsible for any portion of your bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your nsurance carrier. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to vork together to resolve any insurance problem.

Deductible

Your deductible will be verified at the time of service and if you have not met your deductible you are required to pay at the time of service. All Medicare patients have a yearly deductible of $100. Payment for services which qualify toward the yearly deductible begin on January 1 and conclude December 31 of each year. For example, if your yearly deductible is $200, you must first pay the initial $200 to satisfy your deductible. The discount you receive from your insurance company will be calculated when we receive the explanation of benefits for your service and any adjustments will be made at the time.

Co-Payment

All co-payments must be paid at the time of service.

Method of Payment

Please let us know what method of payment you will be using: CASH, CREDIT CARD, or CHECK.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize David M. Alessi, M.D., Babak Larian M.D., and Babak Azizzadeh M.D. to furnish information to insurance carriers concerning this illness and the treatments I receive, and I hereby irrevocably assign to the doctors all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize that photographic copy of this authorization is as if such copy were original. I also authorize the doctors to file a formal written complaint with the insurance commissioner if my insurance fails to pay or deny a claim within 30 days.

I have read, understood and agree to the provisions of this form.

Patient Signature ______________________ Date ____________