

Patient Intake Form for David Schechter, MD

TODAY'S DATE:

PATIENT'S NAME: _____ SEX: MALE FEMALE AGE: _____
LAST FIRST MIDDLE

ADDRESS: _____
CITY STATE ZIP

CIRCLE THE PREFERRED-- CELL: () _____ WORK TEL: () _____ HOME: () _____

BIRTHDATE: ____/____/____ SOCIAL SECURITY #: ____-____-____

E-MAIL (used for lab results) _____ DRIVER'S LIC. #: _____

MARITAL STATUS: (MARRIED____ SINGLE____ DIVORCED____ LIVING TOGETHER____)

OCCUPATION: _____

EMPLOYER: _____

WORK ADDRESS: _____
CITY STATE ZIP

NEXT OF KIN OR EMERGENCY CONTACT: _____ TEL: () _____

RELATIONSHIP: _____

REFERRAL SOURCE: INS. CO WEBSITE CEDARS-SINAI TMS WEB DR. _____
 PATIENT _____ DR. SARNO ATTORNEY _____ OTHER: _____

INSURANCE INFORMATION: PPO WORK COMP PI MEDICARE CASH/CREDIT CARD/CHECK

CARRIER'S NAME: _____ (YOUR CARD WILL BE COPIED)

ASSIGNMENT OF BENEFITS:

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY:

I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and I agree to be financially responsible for non-covered services. The Provider will file my insurance claim only as a courtesy. I understand that if I fail to cancel an appointment with 24 hours notice that I will be charged a fee and that insurance companies typically do not pay this fee; it is my responsibility alone. The fee will typically be \$30-\$100. I understand that I may be charged for completion of forms by the doctor. I understand that failure to pay my bills promptly may result in interest or penalty charges, dating back to the first day the payment was due.

MEDICARE FINANCIAL RESPONSIBILITY:

I understand that the Provider as a Medicare provider is entitled to collect my 20% co-insurance and unfulfilled deductible amount of the Medicare approved service. The Provider accepts assignment for its Medicare patients.

I acknowledge that any lab tests not covered by medicare that are ordered by this office are my responsibility and will be billed directly to me.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Provider to release any information to insurance companies required to process my claim. I have read the doctor's HIPAA notice and understand the priority the office places upon patient confidentiality.

REFERRAL INFORMATION:

I understand that I am ultimately responsible to check on any referral doctor or facility and determine if he/she/it is a provider for my PPO insurance and whether any preauthorization is required.

GENERAL:

I agree that all of the above shall apply to Dr. Schechter's other office, as well.

Patient's Signature

Date