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 WITH ABOVE PERSON: IF MINOR, PARENT INFO:

REFERRAL SOURCE: ☐PATIENT _____ ☐INS. CO WEBSITE ☐DR._____
☐TMS ☐ DR. SARNO ☐BOOK ☐YELP ☐GOOGLE ☐CEDARS-SINAI ☐ OTHER:_____

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

INSURANCE CARRIER'S NAME: _____ (YOUR CARD WILL BE COPIED)
(E.G. BLUE CROSS, AETNA, CIGNA, UNITED HEALTHCARE, ANTHEM, BLUE SHIELD)

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. 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 do not pay this fee; it is my responsibility alone.
The no-show or late cancellation 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, penalty or collection fees, 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 Medicare patients.

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

If I have **medicare**, I will also initial here: _____

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.

GENERAL:
I agree that all of the above shall apply to Dr. Schechter's other office(s), as well. I understand Dr. Schechter is not an HMO provider at all.

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.

MEDI-CAL INFORMATION
If I have medi-cal I will initial here _____.

Patient's Signature	**Date**

(CC) Updated 05 13