Patient Intake Form for David Schechter, MD TODAY'S DATE: PATIENT'S NAME: ___ SEX: DMALE DFEMALE **AGE**: FIRST MIDDLE ADDRESS: ___ CITY CIRCLE THE PREFERRED-- **CELL**: () ______ WORK: () _____ HOME: ()_____ BIRTHDATE: _____/____ PREFERRED NAME :_____ E-MAIL (used for lab results) ______ DRIVER'S LIC. #: MARITAL STATUS: (MARRIED SINGLE DIVORCED LIVING TOGETHER) OCCUPATION: _____ SOCIAL SECURITY #: - -EMPLOYER: WORK ADDRESS: EMERGENCY CONTACT(S): _____ RELATIONSHIP WITH ABOVE PERSON(S): IF MINOR, PARENT INFO: REFERRAL SOURCE: DPATIENT _____ DINS. CO WEBSITE □TMS /SARNO BKS. □"THINK" BOOK □YELP □GOOGLE □CEDARS-SINAI □ OTHER: INSURANCE INFORMATION: PPO DMEDICARE DNONE=CASH/CREDIT CARD/CHECK DWORK COMP DPI INSURANCE CARRIER'S NAME: (YOUR CARD WILL BE COPIED) (E.G. AETNA, CIGNA, UNITED HEALTHCARE, ANTHEM, BLUE SHIELD, BLUE CROSS, PHCS) **ASSIGNMENT OF BENEFITS:** ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY: MEDICARE FINANCIAL RESPONSIBILITY: I hereby authorize payment directly to the Provider. I understand that my Lunderstand that the Provider as a Medicare provider is entitled to collect insurance policy is a contract between myself and my insurance provider my 20% co-insurance and unfulfilled deductible amount of the Medicare and I agree to be financially responsible for non-covered services. approved service. The Provider accepts assignment for Medicare 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

The no-show or late cancellation fee will typically be \$50-\$120. 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

Late payment: 90 days adds \$25; 120 days adds \$50 more. ____ initial

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 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 ____

Dr. Schechter is not accepting medi-cal patients at this time.

Patient's Signature	Date