*Yehuda Handelsman, M.D., F.A.C.P., F.N.L.A., M.A.C.E.*
18372 Clark St. Suite # 212. Tarzana, CA 91356 * Tel. 818 708 9942 * Fax. 818-708 0154

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Mr. Mrs. Ms. _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Preferred: Home/ Cell

Email: _____ **May we contact you via? [] Call [] Email [] Both**

Social Security #: _____ D.O.B: _____ DL#: _____ Exp: _____

Sex: [] **M** [] **F** Marital Status: [] **Single** [] **Divorced** [] **Married** [] **Widowed**

Employer: _____ Phone: _____ Occupation: _____

## SPOUSE/ EMERGENCY CONTACT INFORMATION

Patient Spouse: _____ Cell: _____

**If Patient is a minor, please provide name of Parent/Guardian:** _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

## REFERRAL

Whom may we thank for referring you? _____ Phone: _____

## INSURANCE

YEHUDA HANDELSMAN, M.D., F.A.C.P., F.N.L.A., M.A.C.E.

**PLEASE READ AND INTIAL:**

I authorize the release of any medical information necessary to process all claims.

_____Initial

I understand that I am responsible for payment of any account regardless of insurance coverage of eligibility.

_____Initial

I understand that I am responsible for payment of my account for any non-covered items.

_____Initial

I request that the payment of authorized insurance benefits be made on my behalf to **Yehuda Handelsman, M.D.**, for services furnished to me by the doctor. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the **health care financing administration** of its agents any information to determine their benefits payable for related services.

_____Initial

Most insurance plans and Medicare require that we collect the co-payment, co-insurance, and deductible fees from the patient at the time of the visit.

_____Initial

**I have completely read all the above information and agree to all the terms.**

_____

Signature of patient or guarantor

_____

Date

Any information that we collect about you on this form will be kept **confidential** in our office.

*Yehuda Handelsman M.D., F.A.C.P., F.N.L.A., M.A.C.E*
*Endocrinology*
*Metabolism, Diabetes, Internal Medicine*
*Diplomate American Board of Internal Medicine*
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## FINANCIAL OBLIGATION & ASSIGNMENT OF BENEFITS

Dr. Handelsman's office is a participating doctor in many health plans; to accept insurance plans we must collect all Deductibles and Co-Pays due at the time of service. Since this amount may not be able to be determined toay we ask for a credit card number so as to avoid the extra expense of billing you. If not we must ask for full payment today and then a refund in the appropriate amount will be made after your insurance generates an explanation of benefits.

***Co-Pays and insurance deductibles are due at the time of service for office visits.**

*A credit card is required to guarantee payment of Co-Pays, Deductibles, and Co-Insurance.

*I assign benefits and hereby authorize my insurance carrier to pay Dr. Handelsman directly for services I received from the office.

*I will keep Dr. Handelsman's office up to date on my most current guarantor/health insurance information, my address; my phone number and other contact information so that claims can be processed correctly.

*I am responsible to ensure that my health insurance carrier honors claims submitted to my behalf by Dr. Handelsman's office for services rendered. If my carrier denies my claim, I will promptly contact to determine what additional information is needed to get the claim paid and provide them with any information they request from me.

We require a credit card to be on file for office, co-pays, and deductibles.

**Credit Card Number** **Expiration Date**

**Billing Address**

**Print Name** **Signature** **Date**

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**IMPORTANT INFORMATION**

**PLEASE READ CAREFULLY**

## Dr. Handelsman's office Cancellation Policy:

We have set time aside for you in our busy schedule, and also give you the courtesy of a reminder phone call the day before your appointment.
In return, please give Dr. Handelsman and his staff the courtesy of canceling or rescheduling your appointment, **NO LESS THAN 24 HOURS IN ADVANCE**.
Failure to give **24 hours** notice of cancellation of an appointment, reschedule or a no-show appointment, will result in a charge of **$75.00**
(Not covered by insurance companies).

Not showing for **3 appointments** can result in the patient being discharged from the practice, at the physician's discretion.

**All missed appointments will be documented in the patient's medical record.**

**I have read the above, and understand Dr. Handelsman's office Cancellation Policy.**

_____
**Patient Name**

_____
**Patient or Authorized Signature** (If a dependent or minor)

_____
**Date**

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# CONSENT FORM

**Patient Name:** _____

**Physician:** **DR. YEHUDA HANDELSMAN M.D.**

In connection with the medical services that I am receiving from the above named physician, I hereby authorized the above named physician to disclose any or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. As otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

When providing information to me, information may be transmitted to me by an or all of the following means **(initial all that apply):**

_____ **Telephone messages on a voicemail box.**

_____ **E-mail to the following address:** _____

_____ **Messages to the following family members or friends;**

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## PHARMACY INFORMATION

PATIENT NAME: _____

DOB: _____/_____/_____

PHONE #: _____

PHARMACY NAME: _____

PHARM PHONE #: _____

PHARM FAX #: _____

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PHARMACY NAME: _____

PHARM PHONE #: _____

PHARM FAX #: _____