SHERVIN ESHAGHIAN, M.D.

ATTENDING CARDIOLOGIST, CEDARS-SINAI HEART INSTITUTE
ASSOCIATE CLINICAL PROFESSOR, DAVID GEFFEN SCHOOL OF MEDICINE
CEDARS-SINAI HEART INSTITUTE

RANKED #1 HEART PROGRAM IN THE WEST, USN&WR 2013-2015

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LAST NAME: _____ **FIRST NAME:** _____ **MI** _____ **MR. MRS. MISS DR.**

ADDRESS: _____ **CITY** _____ **ST** _____ **ZIP** _____

SOC. SEC. #: _____ **DR. LIC.#** _____ **BIRTH DATE:**_____

TELEPHONE: **HOME:**_____ **MOBILE**: _____ **OFFICE**: _____

E-MAIL: _____ **GENDER: M / F**

ETHNICITY (Check one): __Non-Hispanic __Hispanic PREFERRED LANGUAGE_____

RACE (Check one): __Caucasian __African American __Asian __Native American __Other_____

EMPLOYER: _____ **EMPLOYER TELEPHONE:**_____

EMPLOYER ADDRESS: _____

NAME OF SPOUSE:_____ **OCCUPATION:**_____

SPOUSES DATE OF BIRTH:_____ **SPOUSES EMPLOYER:**_____

EMERGENCY CONTACT: _____ **RELATION:**_____ **TELEPHONE:** _____

REFERRING M.D. :_____**PHONE:**_____

Are you allergic to any medication?_____ **Please Specify:**_____

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Type of Account: _____MEDICARE ___Private Insurance ___Self-Pay Other:_____

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NOTE: Patients are financially responsible for all services rendered, regardless of insurance. We request that deductible and co-payments be paid at the time of service. We will bill your insurance company as a courtesy.

PRIMARY INSURANCE COMPANY:_____

MAILING ADDRESS:_____

IS THIS THROUGH YOUR EMPLOYER? ____ SPOUSE'S EMPLOYER?_____ **GROUP #:**_____

SUBSCRIBER NAME:_____ **POLICY#**_____ **HOSP?**_____ **MED?**_____

MEDICARE #_____**MEDI-CAL#**_____

SECONDARY INSURANCE COMPANY:_____

MAILING ADDRESS: _____

IS THIS THROUGH YOUR EMPLOYER?_____ **SPOUSES EMPLOYER?**_____ **GROUP #**_____

Consent for Care and Treatment: I, the undersigned, hereby agree and give consent for Shervin Eshaghian M.D., Inc. to furnish care and treatment considered necessary and proper in treating my condition.
Authorization for Signature on File and Release of Information: I, the undersigned hereby authorize the office of Shervin Eshaghian M.D., Inc. to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo stat copy of this authorization shall be valid as an original.
Authorization for Assignment of Benefits: I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Shervin Eshaghian M.D., Inc., and shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to the address on file at the insurance carrier.
Financial Responsibility: I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance..
Cancellation Policy: Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us a 24 hour notice so that we may reschedule your appointment and offer the reserved time to another patient. There may be a charge of ***$50.00 for NO SHOW appointments or cancellations with less than 24-hour notification****. I understand that I will be personally responsible for any cancellation fees.*
I have read and fully understand Shervin Eshaghian M.D., Inc.'s Notice of Information Practices. I understand that Shervin Eshaghian M.D., Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Shervin Eshaghian M.D., Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in Shervin Eshaghian M.D., Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION AND HEREBY AGREE TO COMPLY AS OUTLINED ABOVE.

_____	_____	_____
Patient Name	*Patient Signature*	*Date*

Insurance Information

[PLACE COPY OF CARD(S) HERE]