

# TARZANA ENDOCRINE AND MEDICAL GROUP

- ATIF J. ALAZIZ, M.D., INC.
- MARK L. GELLER, M.D.
- GARY T. TANOUE, M.D.

- JEFFREY P. SALBERG, M.D.
- ARDESHIR SOROUSHYARI, M.D.

**PATIENT INFORMATION: PLEASE PRINT, MANDATORY \* ACCOUNT # \_\_\_\_\_**

**ALL INFORMATION IS REQUESTED PRIOR TO THE PHYSICIAN SEEING YOU.**

\*PATIENT NAME: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Initial

\*DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX  M  F

\*HOME ADDRESS: \_\_\_\_\_  
Street City State Zip

MAILING ADDRESS: \_\_\_\_\_  
Street City State Zip

**IF YOU HAVE A CALL BLOCKING SERVICE ON YOUR PHONE LINES, YOUR CALL WILL NOT BE RETURNED. AN OPEN PHONE NUMBER IS REQUIRED.**

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

\*SOCIAL SECURITY #: \_\_\_\_\_ \*DRIVER'S LICENSE #: \_\_\_\_\_

MARITAL STATUS:  MARRIED  SINGLE  OTHER MAIDEN NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_  
Street City State Zip

SCHOOL NAME: \_\_\_\_\_ FULL TIME  PART TIME

SCHOOL ADDRESS: \_\_\_\_\_  
Street City State Zip

**INSURANCE INFORMATION: PLEASE PROVIDE THE RECEPTIONIST WITH A GOVERNMENT PHOTO ID AND ALL INSURANCE CARDS TO BE COPIED.**

\*PRIMARY INSURANCE COMPANY: \_\_\_\_\_

INSURANCE CO. ADDRESS: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SOC. SEC. #: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATION TO SUBSCRIBER:  SELF  SPOUSE  CHILD  OTHER \_\_\_\_\_

\*GROUP #: \_\_\_\_\_ \*SUBSCRIBER: \_\_\_\_\_ ID #: \_\_\_\_\_ \*EFFECTIVE DATE: \_\_\_\_\_

INSURANCE COMPANY PHONE #: (\_\_\_\_) \_\_\_\_\_ CO-PAY AMOUNT: \$ \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

\*PRIMARY INSURANCE COMPANY: \_\_\_\_\_

INSURANCE CO. ADDRESS: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SOC. SEC. #: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATION TO SUBSCRIBER:  SELF  SPOUSE  CHILD  OTHER \_\_\_\_\_

\*GROUP #: \_\_\_\_\_ \*SUBSCRIBER: \_\_\_\_\_ ID #: \_\_\_\_\_ \*EFFECTIVE DATE: \_\_\_\_\_

INSURANCE COMPANY PHONE #: (\_\_\_\_) \_\_\_\_\_ CO-PAY AMOUNT: \$ \_\_\_\_\_

**SPOUSE INFORMATION OR RESPONSIBLE PARTY:**

SPOUSE NAME: \_\_\_\_\_  
Last First Initial

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX  M  F HOME PHONE: (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
Street City State Zip

SOCIAL SECURITY #: \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY:**

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
Last First Initial

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

I HEREBY GIVE CONSENT FOR TREATMENT BY TARZANA ENDOCRINE AND MEDICAL GROUP. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES PERFORMED ON MY BEHALF IF NOT COVERED BY MY INSURANCE COMPANY.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
PARENT / GUARDIAN

**AUTHORIZATION AND RELEASE:**

ALL CO-PAYMENTS, DEDUCTIBLES & NON-COVERED SERVICES ARE DUE AT THE TIME OF YOUR SERVICE.

I HEREBY AUTHORIZE PAYMENT TO THE PROVIDER FOR MEDICAL AND/OR SURGICAL BENEFITS.

I HEREBY AUTHORIZE PROVIDER TO RELEASE ALL INFORMATION NECESSARY, ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT, TO SECURE PAYMENT FOR SERVICES.

THE FOLLOWING POLICY HAS BECOME NECESSARY BECAUSE SOME HEALTH INSURANCE COMPANIES ARE DENYING LEGITIMATE CHARGES AS A COST CONTAINMENT MANEUVER. WE WILL CONTINUE TO BILL INSURANCE FOR YOUR CONVENIENCE. IF YOUR HEALTH INSURANCE HAS NOT PAID IN 30 (THIRTY) DAYS, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OWED.

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES PERFORMED ON MY BEHALF IF NOT COVERED FULLY BY THE INSURANCE. I UNDERSTAND THE PATIENT BALANCE IS DUE WITHIN TEN (10) DAYS OF THE BILLED STATEMENT. I ACCEPT FINANCIAL RESPONSIBILITY I WILL BE BILLED AN ADDITIONAL \$2.50 FOR EACH ADDITIONAL STATEMENT ON PAST DUE BALANCES.

**CANCELLATION POLICY, EFFECTIVE NOVEMBER 1, 2011:**

**IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE US 24-HOUR NOTICE, OR YOU WILL BE SUBJECT TO A MISSED APPOINTMENT FEE.**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_