LOS ANGELES COLON AND RECTAL SURGICAL ASSOCIATES

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Gary. H. Hoffman M.D. Eiman Firoozmand M.D. Liza Capiendo M.D. Stephen Yoo M.D. Alen Kamrava M.D.

PATIENT REGISTRATION FORM

Select: ◯ Dr. Allen Kamrava ◯ Dr. Gary Hoffman ◯ Dr. Eiman Firoozmand ◯ Dr. Liza Capiendo ◯ Dr. Stephen Yoo

Appt. Date: _____ Sex: ◯ Male ◯ Female

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Birthdate: _____ Age: _____ SSN: _____

Driver's License: _____ State of Issue: _____ Email: _____

Single: _____ Married: _____ Widowed: _____ Separated: _____ Divorced: _____ Partnered: _____

Responsible Party (☐ Check Here if the Same as Above)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Partner ◯ Parent

Phone #: _____ SSN: _____

Patient (Parent's) Employer Information

Company Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Years: ____ Phone #: _____ ☐ Self -Employed

Insurance Company Information

Primary Insurance Company: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Policyholder's DOB: _____ **Policyholder:** ◯ Self ◯ Spouse ◯ Partner ◯ Parent

Subscriber ID#: _____ **Group #:** _____

Secondary Insurance Company: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Policyholder's DOB: _____ **Policyholder:** ◯ Self ◯ Spouse ◯ Partner ◯ Parent

Subscriber ID#: _____ **Group #:** _____

Spouse/Partner Information

Spouse's Full Name: _____

Birthdate: _____ **Phone #:** _____

Spouse Employed By: _____

Primary Care Physician or CSHA IPA

Primary Care Physician Name: _____ **Phone #:** _____

Are you a member of Cedars Sinai Health Associates? ◯ Yes ◯ No

Is HMO Authorization Required? ◯ Yes ◯ No

Referral Source

◯ Physician ◯ Family ◯ Friend ◯ Search Engine ◯ Other

Referral Source or Search Engine Name: _____

Phone #: _____ **City:** _____

Insurance Authorization, Assignment of Benefits and Cancellation Policy:

1. I hereby authorize physician listed above to furnish information to carriers concerning my illness, injury and treatment.

2. I hereby assign to the physician all payments for medical services rendered to myself if the physician is a member of my plan's network.

3. I understand that the above information is not a guarantee of coverage, benefits or payment from the insurance plan listed.

4. I understand that should I cancel a procedure or appointment with less than 24 hours notice, I may be subject to a cancellation fee of the cost of the procedure or appointment.

5. All returned checks will be subject to a $25.00 bank fee.

6. All co-pays, coinsurance and deductibles are due and payable on the day services are rendered or in advance of procedure to be performed.

7. I understand that my outstanding balances are due at the time they become “patient responsibility” unless payment arrangements have been made.

8. I understand that it is my responsibility to verify coverage and benefits with my insurance plan.

☐ By checking the box next to this sentence, I acknowledge that I have read the above and agree to the terms and conditions as stated.

Signature: _____ Date: _____