ZOUHEIR H. ELIAS, M.D. -- A PROFESSIONAL CORPORATION
18350 ROSCOE BLVD. SUITE 401
NORTHRIDGE CA 91325

Interventional Cardiology

Patient Registration Form

Patient information

Your Name: _____ Birth Date: _____ Gender: _____
(First) (MI) (Last)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other Social Security #: ___ ___ ___

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

Primary phone _____ H ☐ W ☐ C ☐ Secondary Phone _____ H ☐ W ☐ C ☐

Cell Phone Number: _____ Cell Phone Carrier: _____

Would you like to participate in the patient portal? ☐ Yes ☐ No ☐ Email: _____

Referring physician: _____ Primary Care Physician: _____

Optional Questions

Preferred Language _____ Race: ☐ American Indian/Native Alaskan ☐ Black/African American

☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino Other _____

Responsible Party ☐ Self

Name: _____ Address: _____

City _____ State: ____ Zip: _____ Phone: _____ H ☐ W ☐ C ☐

Emergency Contacts: ☐ I authorize Zouheir H. Elias, M.D. and/or his staff to release health information to my Emergency Contacts.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Additional Information:

Occupation: _____ Employer: _____

Work Phone: _____ Employer's Address: _____

Insurance Information

Primary Insurance Company Name & Address: (HMO ☐ Yes ☐ No): _____

Relation to Subscriber: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____- _____-_____

Secondary Insurance Company: _____ Relation to Subscriber: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____- _____-_____

Pharmacy

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

☑ I assign all medical/surgical benefits to **Zouheir H. Elias, M.D.** and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

☑ I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosure for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

☑ I have read and understand the information on this form.

_____ _____
Signature Date

Dr. Zouheir Elias -- A Professional Corporation
18350 Roscoe Blvd. #401
Northridge CA 91325

Financial Policy

Thank you for choosing Dr. Zouheir Elias as your healthcare provider. Our goals are to provide you with excellent medical care and minimize your out of pocket expenses and make paying your balance as easy as possible. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

INSURANCE: For the patient's convenience, we file medical claims with insurance plans with which we have an agreement, as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient is to be considered self-pay unless this information is provided to us.

The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between the patient and his or her insurance company. All account balances are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our office.

The patient is expected to know his or her insurance benefits, including the deductible and co-payment. Copayments and deductible are to be paid at the time of service. If the patient does not have medical insurance, or if Dr. Zouheir Elias is not a participating provider with his or her insurance carrier, all charges incurred during the treatment are due and payable at the time of service. If the patient's deductible or co-payment exceeds $500.00 we will contact him or her for a deposit prior to the service being rendered.

ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED A $25.00 CHARGE.

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his or her primary care physician prior to the scheduled visit if a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

CANCELLATIONS/FEES: If the patient is unable to keep a scheduled appointment or procedure, it is his or her responsibility to notify our office at least 48 hours prior to the scheduled appointment or 72 hours prior to the scheduled procedure. Appointments cancelled after this time-frame may be subject to a cancellation fee. Additional fees may also be applied for medical records and for physicians completing paperwork for patients (i.e., Disability, FMLA forms). These fees are not covered by insurance and the patient accepts full financial responsibility for all additional fees.

RELEASE OF INFORMATION: I hereby authorize Dr. Zouheir Elias to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review all activity related to the provider's participation with my insurance plan. I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me, to be paid directly to Dr. Zouheir Elias. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary. I have read and understand this Financial Policy, and by signing am in agreement and accept all terms and conditions described above.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name Date of Birth