STEVEN L. ROSENBLATT, MD
FAMILY PRACTICE
URGENT CARE CERTIFIED

11600 WILSHIRE BLVD., SUITE 320
LOS ANGELES, CA 90025
PHONE: (310) 444.2911 FAX: (310) 444.2993
EMAIL: SROSENBLATTMD@GMAIL.COM

# NEW PATIENT DATA SHEET

Welcome! Please complete form and print legibly. Thank you!

Patient Name: _____
Last First Middle Initial

Patient Address: _____
Street/PO Box Apartment #/Unit #

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Date Of Birth: ____/____/____ Gender: ____Female ____Male Social Security Number: _____

_

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced Other: _____

Employer: _____ Occupation: _____ Work Number: _____

How did you hear about us? _____

Emergency Contact: _____ Cell Number: _____

Relationship to patient: _____ Work Number: _____

**********

## INSURANCE INFORMATION

**Primary Insurance:** _____ Are you the primary subscriber of the insurance?____Yes ____No

If not, who's the primary subscriber (Please print name): _____

Subscriber's relationship to the patient? _____ Subscriber's Date Of Birth: _____/_____/_____

**Secondary Insurance:** _____ Are you the primary subscriber of the insurance? ____Yes ____No

If not, who's the primary subscriber (Please print name): _____

Subscriber's relationship to the patient? _____ Subscriber's Date Of Birth: _____/_____/_____

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# PRIVACY PRACTICES ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

The Notice of Privacy Practices is available for your review in our lobby.

I acknowledge that I read and / or reviewed a copy of the Privacy Practices Acknowledgement.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Today's Date

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# NOTICE OF ASSIGNMENT OF BENEFITS TO A PROVIDER

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

# INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Steven L. Rosenblatt, MD, Family Practice, authorizing this transfer of payment from the insured to the healthcare provider, Steven L. Rosenblatt, MD, Family Practice.

I, _____,
Print Name of the undersigned

hereby absolutely authorize Steven L. Rosenblatt, MD, Family Practice to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payments be sent directly to Steven L. Rosenblatt, MD, Family Practice. I understand that it is the policy of Steven L. Rosenblatt, MD, Family Practice to only bill my insurance company(ies) if they participate in that company's network, and if they do not, it will be my responsibility to bill my insurance company(ies) for reimbursement of my expenses.

I certify that I (or my dependant(s)) have active and valid insurance coverage and have supplied Steven L. Rosenblatt, MD, Family Practice with the up-to-date and correct insurance identification card(s) as well as supplied Steven L. Rosenblatt, MD, Family Practice all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to Steven L. Rosenblatt, MD, Family Practice and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to Steven L. Rosenblatt, MD, Family Practice and I understand that it will be my responsibility to pay Steven L. Rosenblatt, MD, Family Practice for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, an if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court costs, and other expenses incurred as a result of said collection or court date, all actions having a venue of Steven L. Rosenblatt, MD, family Practice, other venues notwithstanding. Further, I understand that there is a fee for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month's bill.

I understand that Steven L. Rosenblatt, MD, Family Practice will report to commercial credit bureaus only when an account becomes delinquent. Accounts having no payments within 30 days of the initial debt notice are considered delinquent for payment purposes. Steven L. Rosenblatt, MD, Family Practice will report a delinquent account to the credit bureau if they do not receive a payment within 62 days of the date of the initial debt notification letter. All delinquent accounts are reported as a "collection account" on the consumer credit report. The debt will remain as a collection account while on the credit bureau report; however, any subsequent payment activity is reported to the credit bureaus on a monthly basis.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorized Steven L. Rosenblatt, MD, Family Practice, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original.

Dated this _____ day of _____ at Los Angele, California.

_____ _____
Printed Name Signature of claimant if other than patient/policy holder