

Yehuda Handelsman, M.D., F.A.C.P., F.A.C.E., F.N.L.A.

18372 Clark St. Suite # 212. Tarzana, CA 91356 * Tel. 818 708 9942 * Fax. 818-708 0154

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Mr. Mrs. Ms. _____ Today's Date: _____

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

Home Phone: _____ Cell: _____ Preferred: Home/ Cell

Email: _____ May we contact you via? Call Email Both

Social Security #: _____ D.O.B: _____ DL#: _____ Exp: _____

Sex: M F Marital Status: Single Divorced Married Widowed

Employer: _____ Phone: _____ Occupation: _____

SPOUSE/ EMERGENCY CONTACT INFORMATION

Patient Spouse: _____ Cell: _____

If Patient is a minor, please provide name of Parent/Guardian: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

REFERRAL

Whom may we thank for referring you? _____ Phone: _____

INSURANCE

Empty box for insurance information.

YEHUDA HANDELSMAN M.D., F.A.C.P., F.A.C.E., F.C.C.A.

Diplomat American Board of Internal Medicine

Endocrinology

Diabetes Metabolism, Internal Medicine

18372 Clark St. Suite 212, Tarzana, CA 91356 *Tel: (818)708 9972 *Fax (818)708 0154

Financial Obligation & Assignment of Benefits

Dr. Handelsman's office is a participating doctor in many health plans; to accept insurance plans we must collect all Deductibles and Co-Pays due at the time of service. Since this amount may not be able to be determined today we ask for a credit card number so as to avoid the extra expense of billing you. If not we must ask for full payment today and then a refund in the appropriate amount will be made after your insurance generates an explanation of benefits.

***Co-Pays and insurance deductibles are due at the time of service for office visits.**

- * A credit card is required to guarantee payment of Co- pays Deductibles, and Co-Insurance.
- * I assign benefits and herby authorize my insurance carrier to pay Dr. Handelsman directly for services I received from the office.
- * I will keep Dr. Handelsman office up to date on my most current guarantor/health insurance Information, my address, my phone number and other contact information so that claims can be Processed correctly.
- *I am responsible to ensure that my health insurance carrier honors claims submitted to my behalf by Dr. Handelsman office, for services rendered. If my carrier denies my claim I will promptly contact to determine what additional information is needed to get the claim paid and provide them with any information they request from me.

We require a credit card to be on file for office, co-pays and deductibles.

Credit Card Number

Expiration Date

Security Code: Billing Street Number

Billing Zip Code

Signature

Date

Patient Name

YEHUDA HANDELSMAN, M.D., F.A.C.P., F.A.C.E.

Endocrinology

Metabolism, Diabetes, Internal Medicine

Diplomat American Board of Internal Medicine

18372 Clark St., Suit 212, Tarzana, CA 91356 * Tel 818 708 9942 * Fax 818 708 0154

IMPORTANT INFORMATION

PLEASE READ CAREFULLY

Dr. Handelsman's office Cancellation Policy:

We have set time aside for you in our busy schedule, and also give you the courtesy of a reminder phone call the day before your appointment.

In return, please give Dr. Handelsman and his staff the courtesy of canceling or rescheduling your appointment, **NO LESS THAN 24 HOURS IN ADVANCE.**

Failure to give **24 hours** notice of cancellation of an appointment, reschedule or a no-show appointment, will result in a charge of **\$75.00**
(Not covered by insurance companies).

Not showing for **3 appointments** can result in the patient being discharged from the practice, at the physician's discretion.

All missed appointments will be documented in the patient's medical record.

I have read the above, and understand Dr. Handelsman's office Cancellation Policy.

Patient Name

Patient or Authorized Signature (If a dependent or minor)

Date

YEHUDA HANDELSMAN, M.D., F.A.C.P., F.A.C.E.

Endocrinology

Metabolism, Diabetes, Internal Medicine

Diplomat American Board of Internal Medicine

18372 Clark St., Suit 212, Tarzana, CA 91356 * Tel 818 708 9942 * Fax 818 708 0154 * E-mail: yhandelsman@pol.net

Consent Form

Patient: _____

Physician: Yehuda Handelsman, M.D., F.A.C.P., F.A.C.E.

In connection with the medical services that I am receiving from the above-named physician, I hereby authorized the above-named physician to disclose any or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- A. Any third party payor covering the medical services of the patient;
- B. Other health care professionals and institutions involved in the delivery of health care to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- E. Pharmacies; and
- F. As otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

When providing information to me, information may be transmitted to me by an or all of the following means **(initial all that apply):**

____ Telephone messages on an answering machine.

____ E-mail to the following address: _____

____ Messages to the following family members or friends;
