E L I T E M E D I C A L C L I N I C
PATIENT REGISTRATION FORM, DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____

YOUR INSURANCE INFORMATION AND PAYMENT RESPONSIBILITY: Please have your current insurance ID card available at each visit. If at any time your insurance should change it is your responsibility to inform our office of the change as soon as possible to accurately file your claims.

The cost of medical care is determined by the nature and complexity for your visit. There is no "flat rate" for examinations and treatment. Your insurance plan is a contract between you and your insurance company. As a service to you, our office makes every reasonable effort to obtain payment according to your coverage.

We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to Elite Medical Clinic and agree to permit us to release the necessary medical information required to secure your payment. While we will use reasonable efforts to ensure that your insurance carrier properly processes your services for payment, the obligation to enforce the terms of your benefit contract is your responsibility. **Payment for treatment you receive from Dr. Houman Kashani and his staff is your responsibility whether your insurance company pays or not**. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.

LAB / X-RAY / DIAGNOSTIC SERVICES: Your test results should be ready 7-10 days (from the day your blood is drawn), or possibly sooner. Some specialized tests or biopsies may take 10 days or longer. **We will notify you immediately if any tests are very abnormal or critical.** Please make sure we have your correct contact information at all times. You can also access your blood test results online at **www.questdiagnostics.com/myquest** (**or** www.labcorp.com/results if you have Healthcare Partners HMO). We unfortunately do not have the resources to contact every patient with normal test results—However, please feel free to email (may take up to 1-3 business days to return email), call (may take up to 1-3 business days to return call) or make an appointment within 7-14 days (after your blood has been drawn or study has been completed) to review the test results. However, if you do get a call from us or have a follow up appointment scheduled, we ask for you to try your best to come in so that we can personally review the test results and its significance—you *may* possibly need further testing and/or medications.

Moreover, Dr. Kashani and his staff may make recommendations based on your complaints and physical examination for further testing including additional blood work, procedure, imaging studies, injections, medications, EKGs, etc. There may be an additional cost based on your insurance benefits. Your insurance may or may not cover all or part of the blood work and/or additional testing being recommended.

I understand and agree it is my responsibility—and not the responsibility of the Dr. Kashani and his staff—to know or understand all aspects of my insurance coverage, including if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment. I understand that I am directly responsible for all deductibles, co-pays, and non-covered charges including laboratory, X-ray, ultrasounds, echocardiograms, vascular studies or other diagnostic or imaging services. I understand that these charges are my financial responsibility. It is my responsibility to find out if my insurance company will pay for additional tests. It is also my responsibility—and not the responsibility of the doctor, his staff, or Elite Medical Clinic—to pay for these tests in the event my insurance company does not pay.

CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND OUTSTANDING BALANCES: All co-payments are due at the time of check-in, prior to your appointment with the provider. By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. In addition, by law, we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits. This policy is in accordance with the legal requirements for collecting patient responsibility amounts. All charges are due and payable 60 days from the date of service. Unresolved outstanding balances may be placed with an outside collection agency. I further agree to pay all collection costs, attorney fees, and other collections that may be incurred to enforce collection of any amounts that are outstanding balances.

Initial_____

PREVENTATIVE EXAM (PPO Patients): An exam on a healthy person with no symptoms to look for hidden disease and give advice on healthy behavior. Getting the right preventive services at the right time can help you stay healthy by preventing disease or by detecting a health problem at an early stage when it may be easier to treat.

THE PREVENTATIVE VISIT ONLY COVERS A BASIC PHYSICAL EXAMINATION, CERTAIN VACCINATIONS, LIMITED BLOOD WORK AND WELL WOMAN EXAMINATIONS (PAP SMEAR).

Does Not Include: Evaluation of new symptoms, medication refills, management of chronic problems, or follow up visits.
Insurance Coverage: Covered by most insurance. On very few occasions your insurance may not cover all or part of the preventative exam and blood work. It is your responsibility to check with the insurance company if your plan covers this examination.

In most cases, PPO insurances cover the preventative exam(s). In the event they do not cover this, I understand and agree that I will be financially responsible for any and all charges for (preventative and non-preventative) services not paid by my insurance for my visits. This includes:

- **Preventative exam or physical**
- **All medical service(s) and follow-up visit(s)**
- **Blood work and other tests**

We want you to be as healthy as you can be any many conditions go undetected as patients don't often feel the symptoms until the disease has progressed significantly. We have identified numerous cases of disorders early through our comprehensive screenings and feel it is our duty to protect you from poor health outcomes. Unfortunately, insurers are now asking patients to bear more of these screening costs—by denying certain blood work we feel is very important.

HMO INSURED PATIENTS: I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment. Please note we are *not* contracted as an urgent care with *any* HMOs or IPAs. Therefore, please contact the number on the back of your card for the nearest urgent care contracted with your HMO. You should receive your authorization(s) by mail in 10-14 days. If you do not receive it, please contact your insurance carrier. **Per our contract with the HMO plans—and per their request, we will unfortunately need to send you to the laboratory for any and all laboratory testing.** We apologize in advance for any inconvenience.

MISSED APPOINTMENTS: Unless cancelled or rescheduled 24-hours in advance, our policy is to charge $25 for missed and late cancelled or rescheduled appointments. Insurance plans will not pay for this charge so please help us serve you better by keeping scheduled appointments.

PATIENT SIGNATURE: _____ **DATE:** _____

CREDIT CARD ON FILE

(You will be asked for a copy of your credit card by the front desk attendant)

Elite Medical Clinic will bill your insurance on your behalf. However, in order to reduce costs associated with collecting any balances remaining after insurance payment, we request authorization to maintain a credit card or debit card on file to cover amounts determined by your insurance to be your responsibility.

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Cardholder Name _____

Credit Card Number _____ Exp. Date _____ / _____ / _____

Security Code _____ Billing Zip Code _____

I, the undersigned, authorize and request Houman M Kashani, MD A Prof Corp/Elite Medical Clinic to charge my credit/debit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me. This authorization will remain in effect until I cancel this authorization in writing.

Name (Print): _____ Signature: _____ Date: _____