AFROUZ GERAYLI, M.D., INC.

PRINT CLEARLY

Patient Information

Referred by:

Patient Name: (First) _____ (M.I**)** _____ (Last**)** _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Sex:☐ Male ☐ Female Date of Birth: ____________ **E-Mail Address**: _____

Phone: Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Marital Status: _____ Ethnicity: _____ Social Security #: _____

1st Insurance Name & Policy: _____ 2nd Ins. Name & Policy: _____

Emergency Contact _____ Relationship to Patient: _____

Phone: Home (_____) _____ Work (_____) _____ Mobile (_____) _____

I hereby consent that Afrouz Gerayli, MD INC. provide me with all the health care services that, at their discretion, is necessary for my treatment. I hereby authorize Afrouz Gerayli, MD INC. the release of any medical or other information necessary to the health plans, government agencies, attorneys, or their representatives for processing the claims. I hereby authorize the health plans, government agencies and attorneys to pay Afrouz Gerayli, MD INC. the medical and surgical benefits allowable as payment towards the total charges for medical treatment and services rendered. I understand that I am fully responsible for the charges resulting from treatment which is not covered by this assignment, and pay them promptly. I am aware that upon using my health plan benefits for any services rendered by any out of network provider; I will be going out of network and exercising my "OPTOUT BENEFITS" choice. I certify that the information contained in this form is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that may have been made in completion of this form. I authorize the use of this signature on all insurance submissions. _____ (INITIAL)

Open Payments Database Policy: For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public." The purpose of the Open Payments Program is to provide transparency regarding such payments in order to inform the public, especially patients, of any potential conflicts of interest that a physician may have in recommending or prescribing a particular drug or medical device, thereby enabling patients to make more informed choices when considering the recommendations of their physician. "The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. _____ (INITIAL)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Afrouz Gerayli, MD INC. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. "If other health insurance" is indicated, my signature authorizes releasing of the information to insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier. _____ (INITIAL)

Patient's Signature _____ Date: _____

(If Applicable)Parent/Guardian Signature: _____