Patient Name:_____ Sex:_____ DOB:_____ Marital Status: S M W D

Referred by:_____ Family MD/Ped:_____

SS#:_____ Email:_____ Cell Ph:_____

Home Address_____
Street Address City State Zip

Home Phone:_____ Work Phone:_____

Employer:_____

Employer Address:_____
Street City State Zip

Parent:_____ Sex:_____ DOB_____ Marital Status: S M W D

Home Address:_____
Street Address City State Zip

Home Phone:_____ Cell:_____ Email:_____

Employer:_____Work Phone_____

Employers Address:_____
Street City State Zip

Parent:_____ Sex:_____ DOB:_____ Marital Status: S M W D

Address:_____
Street Address City State Zip

Home Phone:_____ Cell:_____ Email:_____

Employer:_____ Work Phone:_____

Employer Address:_____
Street City State Zip

INSURANCE INFORMATION

Name of Insurance Plan:_____

Address of Ins. Co:_____
Street Address City State Zip

Phone # of Ins Co:_____ Insured's Name:_____

Insured's ID #_____ Group/Policy #:_____ Co-Pay:$_____

Nearest local relative or friend-not residing with you

_____ Phone:_____

Address:_____
Street Address City State Zip

This will constitute authorization for treatment by the physicians of JONATHAN CORREN, MD, Inc for my child/myself. In the event of default, patient or responsible party agrees to pay all collection fees.
I authorize the Insurance company to pay directly to JONATHAN CORREN, MD,Inc 10780 Santa Monica Blvd., Suite 280, Los Angeles, CA 90025.

I HEREBY AUTHORIZE JONATHAN CORREN, MD,Inc.,TO RELEASE TO MY INSURANCE COMPANY OR OTHER CONCERNED PARTIES INFORMATION PERTAINING TO MY MEDICAL RECORD, HISTORY OR TREATMENT.

Signature of Patient or Guardian:_____

Jonathan Corren, MD, Inc.

Patient Financial Responsibility Agreement

Thank you for choosing Jonathan Corren, MD, Inc. for your health needs. This policy has been designed to inform you of our financial policies and answer any questions you may have regarding payment for services rendered at our facility.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any visit or diagnostic tests ordered by the physician.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount or any other type of benefit limitation for the services I receive.

I understand and agree it is my responsibility to know if the physician I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

If I do not have insurance that covers the service I receive, I agree to pay Jonathan Corren MD, Inc. for professional and clinic services in accordance with the regular rates and terms of Jonathan Corren, MD, Inc.

Assignment of benefits (including Medicare benefits): I hereby authorize and direct payment to Jonathan Corren, MD, Inc. of any insurance benefits at a rate not to exceed Jonathan Corren MD, Inc. actual charges. I understand that I am financially responsible for charges not paid according to this agreement.

I have read and agree to the terms and conditions of service.

Signature:_____ Date:_____

(Signature of patient or responsible party)

Responsible Party Name: _____

Revised 10/15/14/JC

NOTICE OF PRIVACY PRACTICES

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

SUMMARY

By law, we are required to provide you with your Notice of Privacy Practices(NPP). This Notice describes how you medical information may be used and disclosed by us. It also tells how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, please contact our office at 310-312-5050 and a staff member will be glad to answer any questions you have.

Effective date of this notice:_____

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the office and a staff member will answer any questions I have. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICE should it be amended, modified or changed in any way."

_____

Patient or representative(please print)

_____ Date:_____

Signature of patient or representative

( ) Patient refused to sign ( ) Patient unable to sign

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name:

Patient Address:

Medical Record #: Date Of Birth: MM / DD / YY

Other Identifier (Social Security Number):

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my protected health information.

Check all that apply to this request:

☐ Please do not phone me at home. Use this alternate phone number to contact me:

☐ Please do not phone me at work. Use this alternate phone number to contact me:

☐ Please send me mail, including my bills, to this alternate address:

☐ Please do not leave messages on my answering machine.

☐ Please do not mail appointment reminder cards to me.

☐ Please do not contact me by e-mail.

☐ Other Request: (please describe):

I understand that the physician (or provider) to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements. I further understand that in some emergency situations, my protected health information may be released.

Date:	Patient Signature:

RETAIN IN PATIENT RECORD

FOR SECURITY PURPOSES THIS DOCUMENT HAS A COLORED BACKGROUND TO PREVENT UNAUTHORIZED DUPLICATION.

Form 108