Bayview Gastroenterology Medical Corporation
Ali Khademi, D.O.

PATIENT INFORMATION RECORD

(Please Print)

Today's date: | Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:	Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name as it appears on insurance:	Birth date: / /	Address (if different):	Home phone no.: ( )
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Name and type of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy or ID number:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name and type of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr Ali Khademi. I understand that I am financially responsible for all charges incurred regardless of any medical insurance. I understand all charges are to be paid in full within 45 days of treatment. I also authorize Bayview Gastroenterology or insurance company to release any information required to process my claims.

Patient/Guardian signature | *Date*

BAYVIEW GASTROENTEROLOGY

Authorization for Disclosure of Health Information

I hereby authorize Bayview Gastroenterology, its employees, officers, and physicians to disclose information from my chart including all of my health records and the following information:

Patient Name_______________________ Date of Birth____________

Address___________________________ Telephone______________

___________________________ Fax____________________

Covering the period of health care: From (date) ______________

1. I understand that the disclosure of health information may be required by law in some instances, such as reporting of communicable diseases.

2. I also authorize Bayview Gastroenterology, its employees, officers, and physicians to call, fax, and/or send letters to me at above (telephone, fax and address) disclosing my medical information and/or any other information relevant to my relationship with Bayview Gastroenterology.

3. **This information will be disclosed for the purpose of medical billing, transcription and communication with your treating physicians.**

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire upon your request:

    - **I authorize release of records to the following representative (person) in charge of my care:**

____

Name, Address, Telephone and Fax Number

____

5. **Bayview Gastroenterology, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

Signed_________________________ (patient) Date________

_________________________ (or legal representative) Date________

_________________________ (relationship to patient) Date________

Signature of Witness:_________________________________ Date________

BAYVIEW GASTROENTEROLOGY

REQUEST FOR RELEASE OF HEALTH INFORMATION

Patient Name_____________________________ Date of Birth__________________
Address__________________________________
Telephone________________________________

Fax______________________________________

Today's Date______________________________

I hereby
authorize/request____
(Physician/Clinic/Institution), its employees, officers, and physicians to disclose information from my chart including all of my health records to Bayview Gastroenterology.

Bayview Gastroenterology
Ali Khademi, D.O.
4145 Clares Street STE A
Capitola CA 95010

Telephone 831.662.9999
Fax 831.662.9998

Signed___________________________________ (patient)
Date________________
___________________________________ (or legal rep.)
Date________________
___________________________________ (relationship to pt.)
Date________________

BAYVIEW GASTROENTEROLOGY

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices of Bayview Gastroenterology and I have been provided an opportunity to review it.

Patient's Name____Birthdate_____________

Signature____

Date____

Ali Khademi, D.O.
Board Certified
Gastroenterologist

4145 Clares Street
Suite A
Capitola, CA 95010
Phone: 831-662-9999
Fax: 831-662-9998

Dear Bayview Gastroenterology Patients

We are here to serve you and provide you with the best care possible. We ask that you please take note of the following policies of Bayview Gastroenterology:

1. We have a NO-SHOW/ Late cancellation fee of $50-$100. This will be billed to you if you do not give us at least a 48 hour notice prior to cancelling or rescheduling (holidays and Sundays are not included in the 48 hour notice).
   Initials: ______

2. All co-pays are due at the time of service. All deductibles are due at least 2 days prior to procedures. If a deductible applies, we will collect $300.
   Initials: ______

3. To be fair to all patients, for late arrival (more than 10 minutes) to an office appointment, we ask that you either wait until the end of the day to be seen or to reschedule your appointment for another day.
   Initials: ______

4. We allow 2 missed appointments. However, if you miss your third appointment, then we reserve the right to discharge you from our practice. For procedures, if you no show once; you will be discharge from our practice.
   Initials: ______

5. For prescription refills, we would ask that you come in for and office appointment with Dr. Khademi if it has been 6 months or longer since you have been evaluated by the doctor. Please call us at least 6 weeks prior to needing your prescription refill and scheduling your office follow up appointment.
   Initials: ______

6. If you need a prescription refill and have seen Dr. Khademi in the last 6 months, then please call your pharmacy first and then our office. Call us at least one week before you need your refill. It may take up to a week to process your request.
   Initials: ______

I have read the above policies and I hereby acknowledge that I am familiar with and fully understand them. I was given the opportunity to ask questions and received explanation of the above policies.

Signature of Patient/ Parent/ Guardian or Authorized Representative

____

Relationship to Patient: ______________________________

Date: ______________________________