ANDRE YOUSEFIA, MD, INC.

227 W. Janss Rd Suite 100 Thousand Oaks, CA 9130

TAX ID: 20-1136061 - NPI: 1659391258

Patient Name: _____ **Date:** _____

Welcome to the office. Please take a few minutes to complete this form as thoroughly as possible.

Full Name:		Date of Birth:
Address:		Social Security Number:
City / State / Zip:		Driver's License:
Home Phone Number:	Cell #:	Work#:
Email Address (if authorization is given to email you):		Male / Female

Medicare requires that we ask you the following questions, thank you for your cooperation:

Preferred Language:	**Race (physical characteristics):**	**Ethnicity (social groups / shared history):**
	( ) American Indian ( ) Asian	( ) Not Hispanic or Latino
( ) English	( ) Black ( ) White	( ) Hispanic or Latino
( ) Spanish	( ) Other:	( ) Ethnicity disclosure declined by patient.
( ) Other:	( ) Race disclosure declined by patient	

Insurance (*denotes required fields):

Primary Insurance Name: *	Insurance ID#: *
Secondary Insurance: *	Secondary Insurance ID#: *

Nearest Relative:	Cell Phone:
In case of an emergency contact:	Cell Phone:

I hereby authorize all insurance benefits to be paid directly to Andre Yousefia, M.D. and Andre Yousefia, M.D. Inc. ("Provider"). I understand that I am financially responsible for all medical bills. I hereby consent to and authorize the treatment plan, administration of diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the Provider. I further understand that Provider may or may not be contracted with my insurance and it my responsibility to understand my insurance benefits. **There is a $50 cancellation fee if 24-hr advance notice is not given**. I understand that by signing this patient information sheet I have read, understood and agree to the above.

Signature: Date: Referred by:

Telephone: (805) 230-2333
dryousefia.office@gmail.com

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Financial policy

It is our policy to maintain a healthy relationship with our patients while ensuring that insurance limitations do not become a hardship. While, Andre Yousefia MD may / or may not be contracted with your insurance company, our office will bill your insurance as a convenience to our patients. However, we expect patients to pay their share for our services, as specified in your benefits contracts. We will help you determine these amounts. In most cases, we require payment of deductibles, coinsurance, or any other fees that are the responsibility of the patient, as well as any fees and charges that are the responsibility of, but not paid by, the insurer, health plan or other third party payor for any reason, except as otherwise provided by applicable law.

1.1 24-HOUR CANCELLATION NOTICE. In an effort to maintain high patient satisfaction and practice effective patient scheduling our office asks that a patient who cannot keep their scheduled appointment notify our office at least 24 hours before the scheduled time of the visit. If a patient fails to keep their appointment they will be charged the customary fee for the service scheduled, or a minimum of $ 50.00. This cost will be the responsibility of the patient and is not covered by any form of insurance.

1.2 COLLECTIONS. Collection efforts are commenced thirty (30) days after the patient has received their first statement.

1. Thirty (30) days after the first statement is issued, interest will incur on the balance at a rate of 10% per year.
2. After your third statement your account will be reviewed for collections, whereas your account may either be sent to an outside collections agency or your account will experience escalated collection efforts including, but not limited to, filing a legal proceeding against delinquent patients, small claims court, seek a judgment, lien against your assets and/or wage garnishments.
3. Should your account be delinquent, Andre Yousefia MD reserves the right to require cash-in-advance for future medical care.

As this is not the wish of Andre Yousefia MD we ask that you contact us and arrange a payment plan so to avoid collections, our staff will respond promptly with courteous and respect.

1.3 FINANCIAL COUNSELOR. Our office offers a Financial Counselor on staff and available Monday – Friday from 8:30a.m. – 4:00p.m. to discuss and explain collections expectations. Counselors can also contact patients about procedures to discuss expected insurance coverage, patient liability and payment arrangements (if necessary). As a further benefit to you, Counselors perform insurance verification or coverage limitations, deductible status, coinsurance requirements and necessary certifications. A Financial Counselor can be reached by calling (877) 215-AIMM (2466).

1.4 GRIEVANCES. It is important for you to understand that the insurance works for you. In some cases after insurance denies a claim, our office may ask for your involvement to resolve your account. It may be necessary for you file an appeal or grievance with the Department of Insurance or the Department of Labor (depending on your insurance) so that a neutral third party will review the documentation and render a binding judgment. Our office will assist in preparing all the necessary documents and have been successful in 100% of our cases.

1.5 INSURANCE PAYMENTS. Some insurance do not recognize Assignment of Benefits, this means that the insurance will send a check directly to you. In this circumstance, your insurance notifies us of when a check is mailed to you, and when it is cashed. Our office allows 15 days for the patient to forward payment to the office. Thereafter, we will consider you responsible for paying the bill and standard collections efforts will be applicable (see section 1.2).

1.6 LETTERS OF AGREEMENT. Billing office staff will originate any special circumstance agreement. These agreements include but are not limited to, Charity Care or Hardship Cases (due to unemployment or illness) must be executed by both patient and countersigned by Dr. Yousefia be effective. ***All agreements must be in writing to be effective***.

1.7 PAYMENT PLANS. Our office may *consider* providing you with a payment plan that will have your balance paid off within three months. Any defaults will result in standard collections practices of interest, then collections or legal proceedings. Please contact our office for more information, any agreements would be in writing and approved by the doctor.

1.8 Contracted Insurances. We are participating providers with: Medicare, Gold Coast, Blue Cross (PPO plans), Blue Shield (PPO plans), Aetna (PPO), Cigna (PPO). We are NOT contacted with HMOs, United Healthcare, Healthnet or any other plan that is not mentioned in our participating network. If you have an HMO you will need to obtain prior authorization before your visit otherwise the visit will be your financial responsibility. If you have United Healthcare, Healthnet, or any other insurance we are not contracted with, we can bill your insurance using your out of network benefits (if applicable).

I have read, understood and agree to the above: Patient signature/date: _____

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ASSIGNMENT OF BENEFITS

I consent to the release, without prior notice to or additional authorization by me, of all medical information, records or documentation required by any third party payor, billing or collection company, manager, administrator, reviewer or auditor or other third party in connection with the processing, evaluation, review, audit, payment or denial of any claim for payment of any services, supplies, drugs or other items provided by Andre Yousefia, M.D. Inc. and Andre Yousefia, M.D. or his staff to the patient named below.

I authorize and direct that Andre Yousefia, M.D. Inc. and Andre Yousefia, M.D., without prior notice to or additional authorization by me, accept and retain all payments of any insurance, health plan or other third party payor compensation, benefits or reimbursements otherwise payable to or for the benefit of the patient named below. I authorize Andre Yousefia, M.D. Inc. and Andre Yousefia, M.D., at this option, to negotiate, accept or decline alternative payment rates or discounts, and/or to reach settlement on billed claims, without prior notice or additional authorization by me. I understand that I am financially responsible for any co-payments, deductibles, and any other fees that are the responsibility of the patient, as well as any fees and charges that are the responsibility of, but not paid by, the insurer, health plan or other third party payor for any reason, except as otherwise provided by applicable law.

I hereby assign and transfer to Andre Yousefia, M.D. Inc. and Andre Yousefia, M.D., any and all of the benefits, rights, privileges, title and interest of the patient named below in and to any insurance, health plan or other contract or agreement under which the patient is a party, or bound by, or a beneficiary, which rights may include without limitation any and all remedies and causes of action and all review, appeal and grievance procedures arising thereunder or under law or equity, all of which Andre Yousefia, M.D. Inc. and Andre Yousefia, M.D. may assert in his own name or in the name of the patient.

MEDICAL RELEASE

I authorize the release of medical information concerning me to be released to Andre Yousefia, M.D. Inc.. The information that can be released includes all medical records, lab reports, photographs, and insurance coverage. A copy of this form is as good as the original. I hereby release you from all legal liability that may arise from the release of the information requested. I will assume responsibility for any fee that may be incurred due to this request.

NOTICE OF PRIVACY PRACTICES

I have received or have been offered a copy of Andre Yousefia, M.D. Inc. Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

Patient Name: _____ Date: _____

Signature: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods.

Patients name (print):_____ DOB:_____

I request and authorize_____ to release healthcare information of the patient named above to:

Andre Yousefia, M.D.
227 W. Janss Rd Suite 100
Thousand Oaks, CA 91360

This request and authorization applies to:

- All healthcare information (unlimited records)

I also consent to specific release of the following records:
Drug / Alcohol / Substance Abuse _____(initial) Tests for Antibodies to HIV _____(initial)
Psychiatric / Mental Health _____(initial) HIV Diagnosis / Treatment _____(initial)

Restrictions: Permissions for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy r facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

Patient signature: _____ Date signed:_____

Patient's Name (print): _____

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How are we doing?

Since we are constantly trying to improve our services to our patients, your feedback is very important to us. Please take a moment to complete the following:

On a scale from 1 to 5, please rate our services below:

5 – One of the best experiences I've had in a doctor's office.
4 – Better than most experiences in other offices
3 - About the same as other offices I've visited
2 – Worse than in other offices I've visited
1 – I would not return

	1	2	3	4	5 (best)
Ease of scheduling appointments:	❑	❑	❑	❑	❑
Waiting time in reception:	❑	❑	❑	❑	❑
Friendliness of staff:	❑	❑	❑	❑	❑
Cleanliness of office:	❑	❑	❑	❑	❑
Doctor listening to your needs:	❑	❑	❑	❑	❑
Doctor spent enough time with me (not rushed):	❑	❑	❑	❑	❑
Recommended treatment plan:	❑	❑	❑	❑	❑
Timely follow up appointments:	❑	❑	❑	❑	❑
Recommend our office to others:	❑	❑	❑	❑	❑

Suggestions or Comments:

_____

Contact info (optional):_____

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