Healthline Medical Group

15211 Vanowen Street, Suite 105 • Van Nuys, CA 91405

Patient Information

Date:

Patient Name: LAST FIRST INITIAL

Address: NUMBER STREET APT #

CITY STATE ZIP

Home Phone: Cell Phone:

Email:

Social Security #: Birth Date:

Gender: M F (CIRCLE ONE) Marital Status: Driver's License #:

Chief Complaint: Work Related?: Y (CIRC

Employer Name: Phone:

Employer Address:

Occupation:

Emergency Contact

Name: LAST FIRST INITIAL

Address: NUMBER STREET APT #

CITY STATE ZIP

Home Phone: Cell Phone:

Insurance Information

Insured/Guarantor Name: Social Security #:

Relationship to Patient: Self Spouse Parent Birthdate:

Insurance Company Name:

Address:

Policy/ID Number: Group Number/Name:

Have you met your deductible? (circle one) Yes No

Referred by:

Signature of Responsible Party: Date:

CONSENT FOR MEDICAL SERVICES AND FINANCIAL AGREEMENT

1. MEDICAL CONSENT: The undersigned consent authorizes any medical treatment, examination, laboratory procedure, x-ray examination, or physical therapy treatment that may be considered advisable or necessary for the patient in the judgment of the attending physicians.
2. FINANCIAL AGREEMENT: The undersigned agrees, whether signing as a patient or as an agent, that in consideration of the services to be rendered to the patient, the undersigned shall have the obligation to pay the account of the patient with **Healthline Medical Group** in accordance with the regular rates and terms of **Healthline Medical Group** as in effect. Such account shall be due and payable at the time of discharge unless other arrangements are approved in writing prior to such time by **Healthline Medical Group**, which shall have sole discretion whether to approve other payment arrangements. If the patient's account is not paid when due, it shall bear interest from the due date at the maximum for the account of the patient on any deferred basis, and payment is not made when due. **Healthline Medical Group** shall have the immediate right to charge such sum to the credit cards of the undersigned listed hereon, the undersigned's signature(s) herein constituting complete authorization to **Healthline Medical Group** to charge such credit cards. If the patient's account is referred to a collection agency and/or an attorney for collection, the undersigned shall pay all attorneys' fees for costs of collection.
3. MEDICARE: Patient's Certification, Authorization to Release Information, and Payment Request: The undersigned certifies that the information given in applying for payment under the Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf.
4. RELEASE OF INFORMATION: **Healthline Medical Group** may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to **Healthline Medical Group** or to the patient or to a family member or employer of the patient for all or part of **Healthline Medical Group** charges, including, but not limited to, hospital or medical service companies, workmen's compensation carriers, welfare funds, or the patient's employer. All such information would be available after a written request and the approval of the attending physician.
5. RELEASE OF MEDICAL RECORDS: The undersigned authorizes the release of information in the patient's medical records to his/her private physician and to any physician, hospital, or agency to which **Healthline Medical Group** refers the patient. The undersigned also authorizes any physician, hospital, or agency to which the patient is referred the release of information to **Healthline Medical Group** regarding treatment by said physician, hospital, or agency.
6. DISCLOSURE: The x-ray and physical therapy departments are owned and operated by **Healthline Medical Group**. **Healthline Medical Group** bills for services provided by the Orthopedist and other Specialists performing services in this clinic inclusive of the EMG nerve conduction studies.
7. INSURANCE ASSIGNMENT: The undersigned hereby authorizes payment directly to **Healthline Medical Group** of any benefits payable to the patient including disability insurance and payment under Title XVIII of the Social Security Act, which is applicable to the patient's account. The undersigned understands that he/she is financially responsible to **Healthline Medical Group** for the charges not covered by the patient's insurance plan.
8. RELEASE FOR FUTURE CONTACT: The undersigned hereby authorizes **Healthline Medical Group's** staff to contact the patient for information relating to the patient's medical condition.

The undersigned certifies that he/she has read the foregoing and is the patient, or duly authorized by the patient as patient's general agent to execute the above and hereby accepts its terms.

Signature of patient   Date

Witness   Date

Husband, Wife, Guardian or Nearest Relative, or Person Assuming Responsibility for the Account.