DAYA MD

Anil Daya, MD | 32144 Agoura Rd | Suite 206 | Westlake Village, CA 91361 | 805 371–4820

# REQUIRED PATIENT INFORMATION FOR INSURANCE BILLING

## PATIENT

**Patient Name: Last** ______________________ **First** ______________________ **MI** __________

**Address: Street** ____________________ **City** __________________ **APT#** ______ **State** ____ **Zip** ________

**Phone #: Home** ____________________ **Work** __________________ **Mobile** __________________

**Email Address:** ____________________________________________________________

**Marital Status:** **Married** **Single** **Divorced** **Separated** **Date of Birth:** ____________________ **Sex:** **M** **F**

**What is your preferred method of contact?** **Home Phone** **Work Phone** **Cell Phone** **Email**

**Spouse's Name:** __________________________ **Spouse's Email Address:** ______________________

**Spouse's Phone #: Work** ____________________ **Cell:** __________________

**You were referred to this office by:** ________________________________________________

**Emergency contact NOT living with you:** __________________________ **Phone #:** ____________________

## PRIMARY INSURANCE INFORMATION

*If primary insured is **not** the patient, list spouse, parent or other information of primary insured below*

**Please include the Date of Birth of the primary insured for your insurance to be billed.**

### INSURED

**Insured Name:** ________________________________________ **Sex:** **M** **F**

**Date of Birth:** ________________ **Insurance Company:** ____________________________________

**ID #:** ____________________________ **Group #:** ______________________________

**Patient's relationship to insured:** ______________________________________

## SECONDARY INSURANCE INFORMATION

*If secondary insured is **not** the patient, list spouse, parent or other information of primary insured below*

**Please include the Date of Birth of the secondary insured for your insurance to be billed.**

### INSURED

**Insured Name:** ________________________________________ **Sex:** **M** **F**

**Date of Birth:** ________________ **Insurance Company:** ____________________________________

**ID #:** ____________________________ **Group #:** ______________________________

**Patient's relationship to insured:** ______________________________________

**Continue —>**

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## PAYMENT POLICIES

**You are responsible for anything your insurance does not cover.**
**All Co-Pays are due and payable at each visit.**

**Please initial in the boxes below:**

☐ • $5 FEE FOR CO-PAYS NOT PAID AT TIME OF SERVICE.

☐ • $50 NO SHOW FEE FOR ANY MISSED APPOINTMENT that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.

☐ • $35 NSF CHARGE FOR ANY RETURNED CHECK FROM THE BANK

☐ • Assignment of benefits are payable to the doctors.

☐ • If you are a private pay patient without insurance, all charges are due at the time of visit.

**NOTE:** **We do not send statement to private pay patients.**

## PRESCRIPTION POLICIES

**There is a 24-48 hour turn around for prescription refills.**
**If you have not seen the Physician in three–six months, the prescription will be denied.**

## OTHER POLICIES

☐ • I have read & understood the "Notice of Privacy Practices Acknowledgment Form".

## SIGNATURE / DATE

Please sign and date this document showing that you have read and understood our policies.

**Patient Signature:** ______________________________ **Date:** ________________



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# Notice of Privacy Practices Acknowledgement Form

**The notice of privacy practice describes how medical information about you may be used and disclosed and how you can get access to this information.**

**Please review it carefully, as it explains:**

- How this office will use and disclose your protected health information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office Notice of Privacy Practices.

I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

____________________________________ ________________________

Patient or Patient Representative **Signature** Date

____________________________________ ________________________

Patient or Patient Representative **Printed Name** Date

**Who may we share your Medical Information with?** **Spouse** **Parent** **Other**

**Name:** ______________________________ **Phone #:** ________________________

**Where may we leave your Medical Information?** **Home Answering Machine** **Cell Phone**

**Home #:** ______________________________ **Cell #:** ________________________

____________________________________ ________________________

Patient or Patient Representative **Signature** Date

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**Save** the completed New Patient Form for your records by clicking the button below.

**Email** the completed New Patient Form to our Office by clicking the button below.

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