MORRIS SILVER, M.D.

9301 Wilshire Blvd Suite 602

Beverly Hills, CA 90210

PH# (310) 295-9673 FAX# (310) 287-1065

THIS SECTION REFERS TO PATENT ONLY				
NAME	**SEX**	**AGE**	**D.O.B**	**MARITAL STATUS** ☐ **SINGLE** ☐ **SEPERATED** ☐ **DIVORCED** ☐ **WIDOWED** ☐**MARRIED**
ADDRESS			**S.S. NUMBER**	
CITY **STATE** **ZIP**				**HOME PHONE** ( )
WORK PHONE ( )	**CELL PHONE** ( )	**EMAIL ADDRESS**		
CALIFORNIA DRIVER'S LICENCE NO. **OCCUPATION** **CITY** **STATE** **ZIP**				
REFERRING PHYSICIAN **ADDRESS** **CITY** **STATE** **ZIP**				
NAME OF PERSON TO BE NOTIFIED IN EMERGENCY **ADDRESS** **CITY** **ZIP** **PHONE** ( )				
DO YOU HAVE ANY ALLERGIES TO MEDICATION? ☐ **YES** ☐ **NO** **IF YES, WHICH ONE?**			**PHARMACY:**	

INSURANCE INFORMATION			
HEALTH PLAN			
ELIGIBILITY VERIFICATION ☐ **YES** ☐ **NO**	**AUTHORICATION NEEDED** ☐ **YES** ☐**NO**	☐ **PVT. INS.** ☐ **MEDI-MEDI** ☐ **CASH** ☐ **MEDICARE** ☐ **W/C** ☐ **CREDIT CARD** ☐ **MEDI-CAL** ☐ **P.I.**	_____________ **ACCOUNT NO.** **EXP. DATE**
NAME OF INSURANCE COMPANY PRIMARY		**NAME OF INSURANCE COMPANY SECONDARY**	
ADDRESS		**ADDRESS**	
NAME OF INSURED		**NAME OF INSURED**	
POLICY HOLDER (COMPANY NAME GROUP)	**GROUP #**	**POLICY HOLDER (COMPANY NAME GROUP)**	**GROUP #**
POLICY OR CERTIFICATE NO/S.S. NO.	**EFFEC. DATE**	**POLICY OR CERTIFICATE NO/S.S. NO.**	**EFFECT. DATE**
PATIENT IS ☐ **SELF** ☐**SPOUSE** ☐ **CHILD** ☐**OTHER(SPECIFY)** ___________		**PATIENT IS** ☐ **SELF** ☐**SPOUSE** ☐ **CHILD** ☐**OTHER(SPECIFY)** ___________	
☐**MEDI-CAL I.D. #** ☐**MEDI-CARE I.D. #**	**CO-INSURANCE** ☐**YES** ☐**NO $**___________	**HAVE YOU MET YOUR DEDUCTIBLE?** ☐**YES** ☐**NO $**_________	

ACKNOWLEDGEMENT AND AUTHORITY FOR TREATMENT AND PAYMENT

I consent to treatment as necessary or desirable to the patient named above, including but restricted to whatever drugs, medicine, performance of operations, laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designee.
I further understand that the qualified designee in some cases will be the Assistant to the Physician, also called P.A. An Assistant to the Physician means a person who is a graduate of an approved program of instructions in Health Care and is approved by the Board to perform direct patient care serviced under the supervision of a Physician.
I also acknowledge full responsibility for such services and agree to pay for them, in full, AT THE TIME OF SERVICES, If payment is not received within sixty (60) days of service, a finance charge of 1 1/2 % per month will be applied to the unpaid balance. If the physician must use a collection agency/attorney/or court to collect its charges, then I will pay reasonable attorney fees, and costs, incurred in collecting same, regardless of insurance coverage.
The undersigned further assigns to Morris B. Silver, at his election, the right to enforce the undersigned rights under the undersigned's ERISA health plan, if any
I hereby authorize payment directly to **Morris Silver M.D.** of the Medical Expenses
Benefits otherwise payable to me but not to exceed my indebtness to said physician on account of the enclosed charge.

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release Of any medical or other information necessary to process this claim. I also Request payment of government benefits either to myself or the party Who accepts assignment below.

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I Authorize payment of medical benefits to the designated Physician or supplier for services rendered.

SIGNED__________________________DATE__________________ SIGNED________________________________