Welcome to Beverly Hills OB/GYN

Dr.Rabin, Dr. Kornerich, Dr. Goldman, Dr. Banooni, and Dr. Daneshavar

Patient Registration Form

(please fill out completely)

Date:_____ Patient Acct #:_____

Last Name:_____ First Name:_____

DOB:_____ SSN:_____

Mailing Address:_____

_____

*****Please fill out all numbers and email information. For privacy reasons, please let us know if we can leave detailed information about your lab results on your voicemail.****

Circle: Yes or No, ( )Home, or ( )Cell, Patient Signature:_____

Home Number:( )_____-_____ Cell Number: ( ) _____-_____

Email:_____ @_____ Fax Number: ( ) _____-_____

Pharmacy Name/Address/Number:_____

_____

Employer Information

Occupation:_____ Work Number: ( ) _____- _____

Emergency Contact

Name:_____ Relationship:_____

Address:_____ Phone Number:( ) _____-_____

Primary Care Physician

Name:_____ Phone Number: ( ) _____-_____

Referred by: _____

Insurance Information/Guarantor

Guarantor's Name:_____DOB_____

Primary Ins.Name:_____ ID#:_____

Secondary Ins. Name:_____ ID#:_____

HEALTH QUESTIONNAIRE

NAME_____ AGE_____ DATE_____

ADDRESS_____ PHONE_____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes	Strokes	No	Yes	Rheumatic fever or heart disease	No	Yes
Mumps	No	Yes	Cancer	No	Yes	Congenital Abnormalities	No	Yes
Chickenpox	No	Yes	Tuberculosis	No	Yes	Other serious diseases	No	Yes
Diabetes	No	Yes	Venereal disease	No	Yes	_____		

Adult:

Have you had any serious illness? ..... No Yes

Have you ever been hospitalized or been under medical care for very long? ..... No Yes

If yes, for what reason? _____

Operations:

Have you had any surgery? ..... No Yes

List _____

_____

_____

Injuries:

Have you had any broken bones? ..... No Yes

Have you had any head concussions or injuries? ..... No Yes

Have you ever been knocked unconscious? ..... No Yes

FAMILY HISTORY:	If Living: Age	If Living: Health	If Deceased: Age (at death) & Cause	
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has any blood relative ever had:		
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
High blood pressure	No	Yes
Stroke	No	Yes
Convulsions	No	Yes
Suicide	No	Yes
Mental Illness	No	Yes
Bleeding tendency	No	Yes
Gout or other arthritis	No	Yes
Hereditary Defects	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife? ..... No Yes

Do you have dependents at home? ..... No Yes

Alcoholic Beverages: Never_____ Rarely_____ Moderately_____ Daily_____ Ever?_____ ..... No Yes

Tobacco: Cigarettes_____ Packs a day_____ Don't Smoke_____ Ever smoked?_____ ..... No Yes

Are you employed? Full Time_____ Part Time_____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

Education: (Years)

Grade School_____ _____ College_____ Postgraduate_____

How much time have you lost from work because of your health during the past?

Six Months_____ One Year_____ Five Years_____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change?	No	Yes
Have you been in good general health most of your life?	No	Yes

Skin:

Skin Disease	No	Yes
Jaundice	No	Yes
Hives, eczema or rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury	No	Yes
Do you wear glasses?	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness or transient episodes of unconsciousness	No	Yes

Neck:

Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes

Respiratory:

URI(cold)now	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

SYSTEMIC REVIEW:

Respiratory (Cont'd)

Asthma or Wheezing	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or Pneumonia	No	Yes

Cardiovascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath with walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or pain in the abdomen	No	Yes
Does food stick in throat	No	Yes

Genitourinary

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Brights's Disease	No	Yes

Gynecological

Age periods started _____

How long do periods last? _____ Days

Gynecological (cont'd)

Number of pregnancies _____

Number of miscarriages _____

Date of last cancer smear and results _____

_____

Frequency of periods, every _____ days.

Any pain with your periods	No	Yes

Number of children _____ Ages _____

Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose veins	No	Yes
Weakness of muscles or joints	No	Yes
Any difficulty in walking	No	Yes
Any pain in calves or buttocks on walking relieved by rest	No	Yes

Neuro-Psychiatric:

Have you ever had psychiatric care?	No	Yes
Have you been advised to see a psychiatrist?	No	Yes
Do you ever have, or have had, fainting spells?	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematologic:

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery?	No	Yes
Have you had abnormal bruising or bleeding?	No	Yes

Allergic:

Any allergies, including medication	No	Yes

Endocrine

Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before or skin become dryer	No	Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction of sickness following injection or oral administration of:

	Circle One			What Drug or Food?
Penicillin or other antiiotics	Yes	No	Don't Know	
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't Know	
Novocain or other anesthetics	Yes	No	Don't Know	
Aspirin, empirin or other pain remedies	Yes	No	Don't Know	
Sulfa drugs	Yes	No	Don't Know	
Tetanus antitoxin or other serums	Yes	No	Don't Know	
Adhesive tape	Yes	No	Don't Know	
Iodine or merthiolate	Yes	No	Don't Know	
Any other drug or medication	Yes	No	Don't Know	
Any foods, such as egg, milk or chocolate	Yes	No	Don't Know	

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisone	Yes	No	Don't Know
ACTH	Yes	No	Don't Know
Anticoagulants	Yes	No	Don't Know
Tranquilizers	Yes	No	Don't Know
Hypotensives (high blood pressure medicines)	Yes	No	Don't Know
Has the patient ever received treatment for: Asthma, rheumatism or rheumatic fever?	Yes	No	Don't Know
Aspirin	Yes	No	Don't Know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

_____ Doctor

_____ Date

_____ Signature of patient

Stephen Rabin, MD
Nancy Goldman, MD
Karen Kornreich, MD
Peyman Banooni, MD

150 N. Robertson Boulevard
Suite 200
Beverly Hills, CA 90211

Effective Date: April 14, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY!

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

If you have any questions about this notice, please contact our Privacy Officer at 310-652-9347

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected information. PHI is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices.

We may change the terms of our notice at any time.

In the event that we change the terms of our notice, it will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling our office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

WHO WILL FOLLOW THIS NOTICE:

- This notice describes our facility's practices and that of:
- Any health care professional authorized to enter information into your medical chart.
- All areas of this facility.
- Any member of a volunteer or training group that we allow to help you while you are under our care.
- All employees, staff and other facility personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at this facility, whether made by personnel employed by this facility, your personal physician or other practitioners involved with your care.

YOU WILL BE ASKED TO SIGN A CONSENT FORM.

Once you have consented to the use and disclosure of your protected health information (PHI) for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Notice. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment and for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of this office.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

ONCE YOU HAVE SIGNED OUR CONSENT FORM

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. This is not an exhaustive listing. However, all of the ways we are permitted to use and disclose information will fall into one of these categories.

- **FOR TREATMENT.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, clergy or others who are involved with your care. For example, your physician may provide your PHI to an outside physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we provide your PHI to another health care provider (such as a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

- **FOR PAYMENT.** We may use and disclose medical information about you so that the treatment and services you receive by our office may be billed to and payment may be collected from you, an insurance company or a third part. For example, we may need to give your health plan information about the medications you receive from us so that your health plan will pay us or reimburse you. Or obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for hospital admission.

- **FOR HEALTHCARE OPERATIONS.** We may use or disclose, as-needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical personnel, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we use a sign-in sheet at the registration desk where you will be asked to sign your

name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "Business Associates (BA)" that perform various activities (e.g. billing, transcription services) for this practice. Whenever an arrangement between our office and a BA involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also combine medical information we have with that from other facilities to compare how we are doing and see where improvements in the care and services we provide can be improved. We may remove information that identifies you from this set of medical information so that others may use it to study health care and health care delivery without learning who the specific patients are.

➢ **TREATMENT ALTERNATIVES**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

➢ **HEALTH-RELATED BENEFITS and SERVICES**. We may use and disclose medical information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

➢ **FUNDRAISING ACTIVITIES**. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request in writing that these fundraising materials not be sent to you.

➢ **INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE**. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved with your health care. We may also give information to someone who helps pay for your care.

➢ **RESEARCH**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project my involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. We will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at this office.

➢ **EMERGENCIES**. We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If you physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to do so, he or she may still use or disclose your protected health information to treat you.

➢ **COMMUNICATION BARRIERS**. We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

SITUATIONS OF USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

➢ **AS REQUIRED BY LAW**. We will disclose medical information about you when required to do so by federal, state or local law.

➢ **PUBLIC HEALTH RISKS (Health and Safety to you and/or others)**. We may disclose medical information about you for public health activities. We may use and disclose medical information about you to agencies when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

➢ **HEALTH OVERSIGHT**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **LAWSUITS AND DISPUTES**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

➢ **LAW ENFORCEMENT**. We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct in the facility;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS**

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death or to perform other duties authorized by law. We may also disclose PHI to a funeral director to carry out their duties. PHI may be used for cadaveric organ, eye or tissue donation purposes.

➢ **WORKER'S COMPENSATION**. We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

➢ **MILITARY**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

➢ **NATIONAL SECURITY and INTELLIGENCE ACTIVITIES**.

We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

➢ **PROTECTIVE SERVICES for the PRESIDENT and OTHERS**.

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state who conduct special services.

➢ **INMATES**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

➢ **RIGHT TO INSPECT AND COPY**. You have the right to inspect and copy medical information that may be used to make decisions about your health care for as long as we maintain the PHI. Usually, this includes medical and billing records. Under federal law, however, you may not inspect or copy the following records: (1) psychotherapy notes; (2) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

To inspect and copy medical information, please contact our Privacy Officer at 310-652-9437. If you request a copy of the information, we will charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

➢ **RIGHT TO AMEND**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for this office;

- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

➢ **RIGHT TO AN ACCOUNTING OF DISCLOSURES**. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of the medical information about you to others except for the purposes of treatment, payment and operations identified above.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. You request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). For all requests, we will charge you for the cost of providing this list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before costs are incurred.

➢ **RIGHT TO REQUEST RESTRICTIONS**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or a friend. For example, you could ask us not to disclose information about a recent delivery.

We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➢ **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS (Alternate means)**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

➢ **RIGHT TO A PAPER COPY OF THIS NOTICE**. You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this notice at any time by requesting a copy from a member of our staff.

CHANGES TO THIS NOTICE.
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we have about you as well as any information we receive in the future. We will post a copy of the current notice in our waiting area. The notice will contain on the first page, at the top of the left column the effective date. If you want a paper copy of the revised or changed notice, please request one from our front reception area personnel.

COMPLAINTS
If you believe that your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the law that apply to us will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

ACKNOWLEDGMENT OF RECEIPT
PRIVACY NOTICE

for

STEPHEN RABIN, MD
NANCY GOLDMAN, MD
KAREN KORNREICH, MD
PEYMAN BANOONI, MD

150 N. ROBERTSON BOULEVARD, SUITE 200, BEVERLY HILLS, CA 90211

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES** for this office.

_____ _____
Patient's signature ***DATE***

_____
Patient's name print

If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reason why the acknowlegedement was not obtained:

_____

_____

_____

_____ _____
Provider Representative signature ***DATE***

_____
Provider Representative name print

_____
Title of Provider Representative

Peyman Banooni M.D. Obstetrics • Gynecology • Infertility

March 2011 150 North Robertson Boulevard, Suite 200•Beverly Hills, CA 90211 (310)652-9347 • Fax (310)652-3489

Dear Patient,

This is to clarify my office policy. If I am not a provider of your insurance or if you are not insured, then all services are due and payable at the time services are rendered. An itemization of your charges will be provided for reimbursement from your carrier. You may attach this itemization to any claim form your insurance carrier may require.

If I am a provider of your insurance, then copay may be collected if instructed by the insurance carrier. Your insurance will be billed. If your deductible is not met, you will be responsible for any unpaid balance not paid by your insurance company. Please refer to your EOB (Explanation of Benefits) for further explanation, which comes from your insurance company.

In addition to the office visit fees, there may also be additional fees, specimen handling fees, medical supplies, pap smears, biopsies, cultures, blood test, bone densities, and ultrasounds. More than one laboratory may be used to analyze your laboratory tests. Even though your insurance will be billed, you may receive bills from the outside laboratories, and/or our medical office/laboratory separately.

Again, please note those laboratories charged are separate from office visit, consult and/or other procedures performed here in the office.

"I HAVE BEEN NOTIFIED BY MY PHYSICAL/PROVIDER, THAT PAYMENT MAY BE DENIED, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT, AND AGREE TO MAKE SUCH PAYMENTS."

I apologize for any inconvenience and appreciate and understanding and cooperation.

Sincerely,

Peyman Banooni, M.D.

I ACKNOWLEDGE THE ABOVE INFORMATION

SINGNATURE: _____ **DATE:** _____

Peyman Banooni M.D. Obstetrics • Gynecology • Infertility

150 North Robertson Boulevard, Suite 200•Beverly Hills, CA 90211 (310)652-9347 •.Fax (310)652-3489

APPOINTMENT CANCELLATION POLICY

To our valued clients:

Your appointment requires us to reserve a specific amount of time exclusively for your evaluation. We have a policy regarding cancellations and missed appointments that we believe is fair to you, this office and other patients who are waiting for appointments. If you can't keep a scheduled appointment, please call us at least 24 hours in advance to cancel. You may leave a voice message and we'll confirm the cancellation with you. If you fail to give us a 24 hour notice of your cancellation, we may bill you for the visit at $100. Please note that your insurance will not pay for this fee and you are personally responsible for it. Exceptions to this policy will be made for true emergencies only.

Sincerely,

Peyman Banooni, M.D.

I have read and understand the above cancellation policy, and am aware that I will be charged for cancellations or missed appointments.

Print Name _____ Signature _____ Date _____