Uzzi Reiss, M.D.
414 North Camden Drive, Suite 750
Beverly Hills, CA 90210
Tel: 310-247-1300 / Fax: 310-205-0164
www.uzzireissmd.com | info@uzzireissmd.com

Patient Name _____
Patient DOB _____

1. Personal and Identifying Information

First Name		Birth Date	Sex Female
Middle Name		Age	
Last Name		Marital Status	Divorced
Social Security No.		Driver's License No.	
Home Phone No.		Fax No.	
Pager No.		Mobile Phone No.	
E-mail Address (primary)		E-mail Address (2nd)	
Home Address	(Street)		
	(City)	(State)	(Zip)
Occupation		Office Phone No.	
Name of Employer			
Office Address	(Street)		
	(City)	(State)	(Zip)
Name of Spouse			
Social Security No.		Age	
Occupation		Office Phone No.	
Spouse's Employer			
Spouse's Office Address	(Street)		
	(City)	(State)	(Zip)
Your Internet Web or site Information:			
Please indicate the address and telephone number to which you would like all private communication sent	(Address)		
	(Phone No.)		

Uzzi Reiss, M.D.
414 North Camden Drive, Suite 750
Beverly Hills, CA 90210
Tel: 310-247-1300 / Fax: 310-205-0164
www.uzzireissmd.com | info@uzzireissmd.com

Patient Name _____
Patient DOB _____

2. Emergency Contact

Person to Contact			
Relationship		Phone No.	
Contact's Address	(Street)		
	(City)	(State)	(Zip)

Closest relative not living with you	Name		
	Relationship		Phone No.
	Address	(Street)	
		(City)	
		(State)	(Zip)

3. Personal Physician

Name of the Doctor			
Specialty		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)

I authorize you to obtain my medical records from this physician to facilitate your evaluation.

Signature	Date:

4. Allergic to Medications

Medication 1	
Medication 2	
Other medications	

5. Person Who Referred You to Our Office

Name			
Speciality		Phone No.	
Address	(Street)		
	(City)	(State)	(Zip)

Uzzi Reiss, M.D.
414 North Camden Drive, Suite 750
Beverly Hills, CA 90210
Tel: 310-247-1300 / Fax: 310-205-0164
www.uzzireissmd.com | info@uzzireissmd.com

Patient Name _____
Patient DOB _____

6. Other Physicians Recently Consulted

Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)
I authorize you to obtain my medical records from this physician to facilitate your evaluation.			
Signature			Date

7. Billing Information

Billing name			
Relationship		Phone No.	
Billing Address	(Street)		
	(City)	(State)	(Zip)

Uzzi Reiss, M.D.
414 North Camden Drive, Suite 750
Beverly Hills, CA 90210
Tel: 310-247-1300 / Fax: 310-205-0164
www.uzzireissmd.com

Patient Name _____
Patient DOB _____

NOTICE OF INSURANCE PRACTICES AND OF PATIENT FINANCIAL RESPONSIBILITY

By signing this form, I acknowledge that, with respect to services rendered by Uzzi Reiss, M.D., Uzzi Reiss, M.D., Inc., and the Beverly Hills Anti-Aging Center and their employees (collectively "Dr. Reiss"), I understand the following.

No Participation in Insurance Plans: Dr. Reiss does *not* participate in *any* insurance panels, and do not accept assignment from any insurance company. Consequently, I am responsible for payment in full at time of service and charges are determined by Dr. Reiss.

Dr. Reiss may provide me with an itemized statement to present to my insurance carrier. However, I am financially responsible for any charges for services even should my insurer determine that those services are non-covered or are unreasonable, medically unnecessary or inappropriate. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Reiss to take action to secure payment of an outstanding balance.

No Responsibility To Determine Eligibility for Benefits: Dr. Reiss is not responsible for determining eligibility for benefits or for assisting me with collecting insurance benefits and have no responsibility to correspond with or telephone or email any insurer with which they do not participate.

Medicare Status: Dr. Reiss is opted out of Medicare. Dr. Reiss may provide services to Medicare patients under a private agreement; however, Medicare will not be billed for services, and I am responsible for the entire fee charged by Dr. Reiss.

Charges: In addition to the office consultation fee, Dr. Reiss may also charge me for specific services such as blood or urine tests, ultrasound, office surgical supplies and procedures, blood drawing and handling.

Appointment Notice and Cancellation Fee: Dr. Reiss requires at least 48 hours advance notice prior to cancellation of any scheduled appointment. If you miss your scheduled appointment, or cancel with less than 48 hours advance notice, we will charge a cancellation fee of $350 to your credit card. You hereby authorize this charge by providing the information below.

Credit Card Number: _____ Name as it appears on the card: _____

Credit Card Type: _____

Experation Date: _____ CCV: _____

_____
Signature

Return of Products: Returned products returned within 10 days of purchase that are unopened and in resalable condition (in the sole discretion of Dr. Reiss) may be returned for credit against future purchases, less a 15% re-stocking fee. No cash refunds are given. Products after 10 days will not be accepted.

No Refunds. Dr. Reiss does not offer any refund for office visits or services of any kind.

Uzzi Reiss, M.D.
414 North Camden Drive, Suite 750
Beverly Hills, CA 90210
Tel: 310-247-1300 / Fax: 310-205-0164
www.uzzireissmd.com

Patient Name _____
Patient DOB _____

I have carefully read this form and acknowledge that I understand it. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

If someone other than the patient is signing this form, indicate name of person, title and authority to sign this form below:

_____

Name

_____

Title/Relationship to Patient

Please provide Authority to Sign Document: _____

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

Our practice uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our practice.

How Our Practice May Use or Disclose Your Health Information

For Treatment. Our practice may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your records that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. Our practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. Our practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff
- Assess the quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. Our practice may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by law. Our practice may use and disclose information about you as required by law. For example, our practice may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Our practice may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of your or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulation related to Workers' compensation.

Other uses. Other uses and disclosers will be made only with your written authorization and you may revoke the authorization except to the extent our practice has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.522; however, our practice is not required to agree to requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- Request communications of your health information by alternative means or at alternative locations; and
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Complaints

You may complain to our Privacy Officer and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Our Practice

- Our practice is required by law to:
- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative location; and

Our practice reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by in office handouts or via our website.

Contact Information

If you have any questions or complaints, please contact

PRIVACY OFFICER:

Uzzi Reiss, M.D.
414 N. Camden Dr. #750
Beverly Hills, CA 90210
310-247-1300

Patient: _____

Signature: _____

Date: _____