Moses J. Fallas, M.D., FACS

PATIENT REGISTRATION

PATIENT NAME:		**DATE OF BIRTH:**	**SEX:** ☐ Female ☐ Male	**APPOINTMENT DATE:**
ADDRESS:	**APT:**	**CITY:**		**STATE / ZIP CODE:**
PRIMARY PHONE: ☐ Cell ☐ Home ☐ Work		**SECONDARY PHONE:** ☐ Cell ☐ Home ☐ Work		**SOCIAL SECURITY NO.:**
EMPLOYER:		**EMPLOYER ADDRESS:**		**HOW DID YOU HEAR ABOUT OUR PRACTICE?**
PRIMARY CARE PHYSICIAN:		**ARE YOU HERE BECAUSE OF A JOB RELATED INJURY OR ACCIDENT?** ☐ YES ☐ NO		**EMAIL ADDRESS:**

OTHER CONTACTS

Emergency Contact	NAME:	RELATIONSHIP:	PHONE:
Responsible Party (Person paying the bill or parent. Complete if different from patient)	GUARANTOR NAME:	RELATIONSHIP:	PHONE:
	ADDRESS:	GUARANTOR DOB:	GUARANTOR SSN:

INSURANCE INFORMATION

Primary	COMPANY NAME:	INSURED'S SSN:	ID NO:
	INSURED'S NAME:	INSURED'S D.O.B.:	GROUP NO:
	EFFECTIVE DATE:	SEX: ☐ Female ☐ Male	INSURANCE TYPE:
Secondary	COMPANY NAME:	INSURED'S SSN:	ID NO:
	INSURED'S NAME:	INSURED'S D.O.B.:	GROUP NO:
	EFFECTIVE DATE:	SEX: ☐ Female ☐ Male	INSURANCE TYPE:

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Moses J. Fallas, M.D. I acknowledge that I am financially responsible for payment whether or not covered by insurance. **I acknowledge that the above information is true and correct.**

Signature **Date**

Moses J. Fallas, M.D., FACS

Brendan J. Carroll, M.D.,FACS

Patient History Form

Patient Name: _____ Date of Birth: _____

Present problem (why you are here)? _____

_____

Today's Date: _____

Medical History

Current Medications (or attach list):

_____

_____

_____

- ☐ COUMADIN
- ☐ PLAVIX
- ☐ ASPRIN
- ☐ Pradaxa
- ☐ Xeralto
- ☐ Eliquis

Drug or Anesthesia Allergies:

_____

_____

Do you have sleep apnea?_____

Previous Illnesses

_____

_____

_____

_____

_____

_____

Previous Surgeries

_____

_____

_____

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_____

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Check any substance(s) you use and describe how much you use:

- ☐ Alcohol_____
- ☐ Drugs/Herbals_____
- ☐ Tobacco_____

Review Of Symptoms

Currently have or have had in the past year:

General:
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss

Cardiovascular:
- ☐ Chest pain/Angina
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Ankle/Leg Swelling
- ☐ Irregular heartbeat
- ☐ Angioplasty/Stents
- ☐ Heart Attack/MI
- ☐ Pacemaker/Defibrillator

Pulmonary:
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Asthma

Hepatobiliary
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Jaundice
- ☐ Hepatitis

Gastrointestinal
- ☐ Incontinence
- ☐ Reflux
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Irritable Bowel
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Cancer
- ☐ Vomiting Blood
- ☐ IBD/Chron's Disease

Genitourinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Difficult Urination
- ☐ Prostate Disease

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures/Epilepsy
- ☐ Stroke

Endocrine
- ☐ Adrenal
- ☐ Thyroid
- ☐ Diabetes
- ☐ Use Steroid/Hormones

GYN
- ☐ Pregnant
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Breast Cancer
- ☐ Abnormal Mamo
- ☐ Abnormal Period

Musculoskeletal
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ DVT (blood clot in leg)
- ☐ Back Pain
- ☐ Joint pain/swelling
- ☐ Sore that won't heal

Skin
- ☐ Abnormal moles/lumps
- ☐ Change in moles/lump
- ☐ Bruise/bleed

Conditions you have ever had:
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Bleeding Disorders
- ☐ Transfusions
- ☐ Ulcers
- ☐ Tuberculosis

Additional Information you want the Doctor to know:

_____

_____

_____

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_____

_____

_____

Moses J. Fallas, M.D., FACS
Brandon J. Carroll, M.D., FACS
9001 Wilshire Blvd. Suite 304
Beverly Hills, CA 90211
310-855-1023 (Fallas)
310-854-0151 (Carroll)
310-855-1024 (Facsimile)

Required Notifications

Dear Patient:

There are several notifications which we are required to give you to be in compliance with various law and regulations. Please take the time to read these notices as they contain important information.

If you like you may keep the attached notice, however to reduce our use of paper, you may return any unwanted copies to us.

Please indicate, by initial and signature, that you have read the following notices.

_____ Notice of financial and insurance policies for all non-Medicare patients

_____ Notice of Surgery Center affiliations

_____ Notice of privacy practices (to be in compliance with HIPPA laws)* you will receive this notice upon your arrival in the office. You may initial at that time.

Please don't hesitate to see me should you have any questions, problems or concerns.

Thank You,

Dyana Yates.

Office Manager

IMPORTANT NOTICE: PLEASE READ

Dear Patient:

We appreciate the opportunity to be of service to you. Our office is dedicated to excellence in patient care. To maintain our excellence in providing you with such care we believe it is important that we communicate our policies regarding payment and insurance issues.

Doctors Fallas and Carroll are not providers for any private insurance companies. This means that we do not set our fees based on the recommendations or allowances of your insurance company(s). Therefore you may be responsible for additional fees for this procedure above what your carrier pays.

You will be asked to make payment at the time of service for all care provided in the office. We will give you all the forms necessary for reimbursement from your insurance company.

If surgery is necessary we will discuss all fees and payment arrangements with you in advance of surgery. We ask that you sign the authorization below. We will hold it and use it only for any surgery of complex procedures you may have.

If you have any questions please do not hesitate to speak with a staff member, prior to seeing your doctor.

Thank you,

Dyana Yates, Office Manager

Authorization to Pay Physician

I, _____, hereby authorize _____
Insurance Company to pay by check made out and mailed directly to:

- ☐ Moses J. Fallas, M.D.
- ☐ Brendan J. Carroll, M.D.

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee.

I agree to pay, in a current manner, any balance said professional charges over and above this insurance payment and if there is no payment, I agree to pay all charges within a four month period from the date of service.

If it is necessary to enforce this agreement, I will be responsible too all attorney, court and collection fees. A copy of this assignment will be considered as effective and valid as the original.

I have been informed of the financial policies of the office of Moses J. Fallas, M.D. and Brendan J. Carroll, M.D.

Signature of policy holder/person responsible for payment: _____

Printed name: _____

Patient name (if different from above): _____

Subscriber's name (if different from patient): _____

Subscriber's social security number (if different from patient): _____

Today's date: _____

MOSES FALLAS, MD

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Patient Name _____ Insured I.D.:_____

INSURANCE COMPANY / PLAN ADMINISTRATOR / PLAN FIDUCIARY

TO: INSURANCE COMPANY _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), **as my designated Authorized Representative(s),** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my providers / Moses Fallas, MD in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

APPENDUM TO PATIENT FINANCIAL RESPONIBILITY

To: **MOSES FALLAS, MD**

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me but the money paid by the insurance company belongs entirely to you. I, therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and agree that I am legally responsible for any charges for service rendered to me and I will pay all fees including any co-pays or deductibles, if applicable.

NOTE: Please read the above agreements carefully and make sure that you understand all the terms and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above.

Agreed and Accepted by:

_____

PATIENT SIGNATURE PATIENT PRINTED NAME DATE