Edward Taras, M.D., FACOG, Inc. & Ian H. Taras, M.D., FACOG, www.DrTaras.com
6325 Topanga Cyn.. Bl. #535, Woodland Hills, CA 91367, (818) 887-0050, FAX (818) 887-5500

PATIENT REGISTRATION

Patient Name: ______ Maiden Name: ______ Birthday: ______

Street Address: ______ Marital Status: S M W SEP D

City: ______ State: ______ Zip: ______

E-Mail (Important): ______ ***Cell Phn #:*** ______

AUTHORIZATION TO RELEASE INFORMATION

I authorize and request that you release to Dr. Taras, or that he may release to you, the complete History & Physical, Progress Notes, Labs (including HIV results), Radiology Reports, Operative Reports, and/or discharge summaries in your possession as it pertains to my care and the practice of Obstetrics, Gynecology & Primary Care. I am aware that Dr. Taras will not re-disclose this health information unless specifically required or permitted by law. I am aware that this form will suffice without further special authorization or consent as provided by HIPAA [164.502(1)(ii) & (vi) + 164.512(1)(i)]. This authorization is subject to written revocation by the undersigned at any time. I permit a copy of this authorization to be used in the place of the original.

______ ______ X ______

Date (Expires 5 Years From Signature Date) | Print Name | Signature (Patient, Parent or Guardian)

PATIENT EMPLOYER INFORMATION

Employer name: ______ Ofc Tel. #: ______

Patient's Occupation: ______

EMERGENCY + INFORMATION

Referred by: ______

Spouse's Name: ______ Spouse's Work/Cell Tel #: ______

Spouse's Employer: ______ Spouse's Occupation: ______

Emergency Contact: ______ **Tel.#:** ______ **Relationship:** ______

Name of Pharmacy: ______ **Phone #:** ______

INSURANCE AND ASSIGNMENT OF BENEFIT

Primary Insurance Co. Name: ______ Secondary Insurance Co. Name: ______

If different than patient, Primary Policy Holder's Name/DOB/SS#: ______

I hereby authorize Dr. Taras to apply for benefits on my behalf for covered services rendered by him, or by his order. I authorize Dr. Taras to perform necessary laboratory test (including but not limited to HIV-The AIDS Virus) and then bill accordingly through the office or via a third party laboratory. It is my responsibility to obtain lab results within a reasonable amount of time, and to provide the office with information regarding a contracted laboratory, if applicable. If mutually agreed upon, I consent to electronic &/or video (telehealth or **telemedicine**) consultation. My excessive missing or canceling of appointments is subject to dismissal from The Practice.

I request that payment from my insurance company be made directly to Dr. Taras. I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I understand that Dr. Taras will bill, as an **(OON) Out Of Network provider,** many insurance plans for me but that each one has different rules, regulations and stipulations. I further understand that these stipulations are constantly evolving and although Dr. Taras and his office attempt to stay current, ***it is ultimately my fiscal responsibility for any unpaid balance.*** I understand that it is my responsibility to provide the office with correct insurance information necessary to file the claim. It may become necessary for me to bill for myself, or for the office to enlist my assistance in securing reimbursement. ***I further UNDERSTAND that DR. TARAS is NOT in-network with ANY INSURANCE!***

I certify that the information I have with regard to my insurance coverage and patient registration information is correct, and that I will inform Dr. Taras of any changes as they become available. I realize I can ask for a copy or view Dr. Taras' HIPAA privacy information @ www.DrTaras.com. Either I, or my insurance company may revoke (in writing) this authorization at any time.

______ ______ X ______

Date | Print Name | Signature (Patient, Parent or Guardian)