

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 _____ Date of Birth _____ SS# _____
Street Address _____ Marital Status: S M W Sep D _____
City _____ State _____ Zip _____
Tel # Home _____ Fax # _____ Maiden Name: _____
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 redisclose 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 _____ Print Name _____ Signature (Patient, Parent or Guardian)
(Expires 7 Years From Signature Date)

PATIENT EMPLOYER INFORMATION

Employer name _____ Ofc Tel. # _____
Employer street address _____ City/State _____ Zip _____
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 _____

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 request that payment from my insurance company be made directly to Dr. Taras or to the party who accepts assignment. I authorize 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 authorize Dr. Taras to perform necessary laboratory tests (including but not limited to HIV-The AIDS Virus) and then billed 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. My excessive missing or canceling of appointments is subject to dismissal from The Practice. I understand that Dr. Taras accepts many insurance plans, and 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, especially as it pertains to Point Of Service (POS) insurance. 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 DOES NOT ACCEPT ANY HMO (OR IPA) INSURANCE, or ANY Health Net Insurance!

I certify that the information I have reported 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)