ALAIN KARAGUEZIAN M.D.

18546 Roscoe Blvd Suite 304 Northridge, CA 91324
(818) 772-7100 office! (818) 772-7112 fax I http://dralaink.com

WELCOME TO OUR OFFICE

We will do everything we can to provide you with the highest quality medical care. We ask of you, our patients, to help us to do this. Please try to make appointments.

This is not a walk-in facility and patients are treated by appointment. We do have same day appointments available, just please contact our office. In order to meet insurance requirement we need to know of any changes in the following:

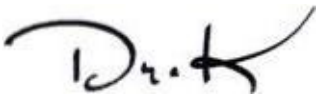
- Insurance coverage.
- Phone numbers, addresses and email

Please note the following:

- We ask that you please show proof of insurance.
- Your office visit co-payment is collected at the time of service.
- You agree for payment for any service not covered by insurance.
- **Any past due bill MUST be collected before you are brought in to see your doctor**.
- We accept cash, check or credit card(s).
- We allow a 15 minute grace period for all appointments. If you are later than this, you may be rescheduled at our discretion. Please remember to sign in under the doctor that you are scheduled to see. **"No show appointments" will be charged $50 per each 15 minute appointment time slot. (Note: annual physicals are 30 minutes long.) Three consecutive "no shows" is cause for patient dismissal.**
- The office reserves the right to charge interest on any unpaid balances at a rate ranging from 12-18% per year (I.e. 1-1.5% per month).
- We try to see our patients in a timely manner. Please try to limit your time with the doctor to the issue(s) for which you originally scheduled your visit. The primary reason for the doctor to run late is patient scheduling for one problem, and then asking the doctor to address many problems. We ask you to PLEASE be patient on days that we are running late.

  Thank you.

I acknowledge receipt of practice policies.
I agree to be personally responsible for service not covered by my insurance plan within 60 days of service.
Name: _____Patient's Signature_____ Date:_____



DATE _____

PATIENT: _____

_____

RESPONSIBLE PARTY (if a minor)

_____

STREET ADDRESS _____

SEX M ❑F❑ AGE_____BIRTHDATE _____ ❑ SINGLE ❑ MARRIED❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

PATIENT EMPLOYED BY _____

BUSINESS ADDRESS

OCCUPATION_____ BUSINESS PHONE _____

SPOUSE (or responsible party) EMPLOYED BY_____

BUSINESS ADDRESS _____

OCCUPATION_____ BUSINESS PHONE _____

PURPOSE OF VISIT _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

DO YOU HAVE MEDICAL INSURANCE Y❑ N ❑ DO YOU HAVE AN ADVANCE DIRECTIVE? ❑Y ❑ N

NAME OF PRIMARY INSURER_____

CONTRACT # _____ GROUP# _____ CLAIM ID# _____

NAME OF SECONDARY INSURER

CONTRACT # _____ GROUP# _____ CLAIM ID# _____

❑ MEDICARE ❑MEDICAL CLAIM ID# _____

IF WELFARE, YOUR NUMBER_____

IN CASE OF EMERGENCY. WHO SHOULD BE NOTIFIED?_____PHONE _____

YOUR DRUGSTORE NAME:_____

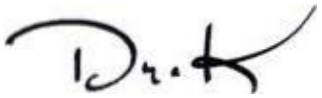
HOW DID YOU LEARN OF OUR PRACTICE? _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits. for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____hereby authorize MY INSURANCE COMPANY to pay and hereby assign directly to all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further understand that any insurance benefits, when received and paid to Dr. Karaguezian will be credited to my account in accordance with the above.

_____ (**AUTHORIZED SIGNATURE OF SUBSCRIBER)**

_____DATE



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NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

CURRENT MEDICATIONS

_____ _____ _____

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

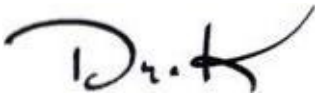
❑ Y ❑ N ❑ Unsure Penicillin or other antibiotics
❑ Y ❑ N ❑ Unsure Morphine, Codeine, Demerol or other narcotics _____
❑ Y ❑ N ❑ Unsure Novocain or other anesthetics
❑ Y ❑ N ❑ Unsure Aspirin, empirin, or other pain remedies
❑ Y ❑ N ❑ Unsure Sulfa drugs
❑ Y ❑ N ❑ Unsure Tetanus antitoxin or other serums
❑ Y ❑ N ❑ Unsure Adhesive tape
❑ Y ❑ N ❑ Unsure Iodine or merthiolate
❑ Y ❑ N ❑ Unsure Any drug or medication; If so, which: _____
❑ Y ❑ N ❑ Unsure Any foods, such as egg, milk. Chocolate; If so, which:_____
_____

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

❑ Y ❑ N ❑ Unsure Cortisone
❑ Y ❑ N ❑ Unsure ACTH
❑ Y ❑ N ❑ Unsure Anticoagulants
❑ Y ❑ N ❑ Unsure Tranquilizers
❑ Y ❑ N ❑ Unsure Hypotensives (high blood pressure medicines)
❑ Y ❑ N ❑ Unsure Has the patient ever received treatment for asthma, rheumatism, or rheumatic fever
❑ Y ❑ N ❑ Unsure Aspirin

SOURCE OF INFORMATION (if other than patient) _____

_____ _____
DATE SIGNATURE OF PATIENT



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RELEASE OF MEDICAL INFORMATION

Consent for release of medical records for _____ _____
Name of Patient _____ Date Requested
_____[signature of Patient]

Requesting records from:

Name of practice _____
Name of physician _____
Fax number
Address _____

Types of records we are requesting:

- ❑ Doctor Notes
- ❑ Nurses notes
- ❑ Discharge summary
- ❑ Lab reports
- ❑ History and physical
- ❑ Consultations
- ❑ Radiology reports

❑ **Records within the following dates:**

- ❑ All records for this patient
- ❑ Records dated between _____and _____

Please send records to:

Attention: Alain Karaguezian, **M.D.**

At fax number: (818) 772-7112

Or mail to: 18546 Roscoe Blvd # 304
Northridge, CA 91324

FOR ANY QUESTIONS PLEASE CALL (818) 772-7100

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NOTICE OF PRIVACY

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change so please read in full. If you have any questions about our Notice of Privacy Practices please contact:

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If acknowledge receipt of the Notice of Privacy Practices:

Patient's Signature_____ Date_____

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.