EMAD KHALEELI MD
Concierge ♥ Cardiology
4305 Torrance Blvd, Suite #301, Torrance, CA 90503
Telephone (310)793-4327♦ FAX(310)793-4307

Welcome-

Thank you for contacting my office for further medical care. While we offer both a traditional Cardiology Care practice and a Traditional Internal Medicine practice in our office, we also offer a Concierge Medicine alternative for those who are interested, as practice where we will get to know you as a person, and act in concert with you, as partners in your health care. In this model, you will note there is more time to deliver personalized care which is directed at preventative care rather than reactionary care.

It has widely been noted that concierge type practices are able to demonstrate better, more modern and guideline based medical care which leads to better control of chronic conditions and ultimately results in fewer Urgent Care Center and ER visits, as well as hospitalizations. If you are interested, please continue to review this website and call for more information.

For those not interested in the concierge level of care at this time, we thank you for your consideration. We are happy to continue to assist in your **cardiac care** as the specialty side of the practice. I ask that you can please print out this document in its entirety and fill it out to the best of your ability. Once completed, please **drop** it off, **mail** it, or **fax** it back to us. This will expedite the process in getting you an office visit. However, due to HIPAA laws and privacy concerns, we do not accept personalized information to be *emailed* back to us at this time. Sorry for this inconvenience. Once we have your completed packet, we will review your insurance information as provided by a copy of your card, both front and back, and can then make an appointment for you, typically within the week, and often in the next few days after receipt of the completed packet.

Our contact information is as follows:

Emad Khaleeli, MD
4305 Torrance Boulevard, Suite #301,
Torrance, Ca 90503.

FAX# (310)793-4307

Should you have any questions, please feel free to call us at (310)793-4327. Should we be busy with patients at the time of your call, please leave a message and we will return your call as soon as possible.

EMAD KHALEELI MD
ERICA BUCK NP, ACNP-C
4305 Torrance Blvd, Suite #301, Torrance, CA 90503
Telephone (310) 793-4327 (HEART) ♦ FAX(310)793-4307

PERSONAL INFORMATION

DATE:_____/_____/202___ BILLING ID# _____ CHART ID#: _____

AT EVERY VISIT- PLEASE PROVIDE INSURANCE CARDS (FRONT AND BACK), DRIVERS LICENSE OR OTHER PHOTO ID FOR COPY-IT IS YOUR RESPONSBILITY TO PROVIDE CHANGES IN INSURANCE PRIOR TO VISIT

PATIENT INFORMATION

♥_____ ♥_____ ♥_____

LAST NAME **FIRST NAME** ***MIDDLE NAME***

DATE OF BIRTH:_____/_____/_____ **SOCIAL SECURITY NUMBER**:_____-____-_____

GENDER (Please Circle one)**:** MALE FEMALE OTHER: _____

MARITAL STATUS: SINGLE MARRIED- Spouse's Name:_____

(Please Circle one): RETIRED EMPLOYED- Full Time Part Time

Nature of job (now **OR** in the past): _____

PRIMARY/FAMILY PHYSICIAN or **REFERRING MD**:_____

Do you have an **ADVANCE HEALTH CARE DIRECTIVE**? ☐ NO ☐ Yes. If so, please list agents.

Primary Agent/ Phone#:_____ Alternate Agent/Phone #:_____

CONTACT INFORMATION

ADDRESS: _____**California**, _____
NUMBER STREET APT# CITY STATE ZIP CODE

PLEASE ☑ **CHECK ONE (1)** BOX BELOW for **PREFERRED** TELEPHONE # at which to ***FIRST*** contact you:

☐ CELL (_____)_____-_____ ☐ WORK (_____)_____-_____

☐ HOME (_____)_____-_____ ☐ OTHER (_____)_____-_____

PLEASE NOTE: THIS WILL HELP PROVIDE YOU ACCESS TO **YOUR** PERSONAL HEALTH RECORD

EMAIL ADDRESS (***YOUR*** e-mail address &/or ***OTHER*** RESPOSNIBLE PARTY- ie/ spouse, child, caregiver):

_____@_____•_____ ♥_____@_____•_____

Practice to Patient Messaging: Please **Circle/Initial** if you approve receipt of this mode of communication:
ON OFF- **Voice** Reminders and Messages
ON OFF- **E-mail** Reminders and Messages
ON OFF- **SMS Mobile Text** Reminders and Messages (fees may apply, check with carrier)
_____ **CONSENT**- to receive Email, Automated/Text and Voice Messages at the phone number(s) provided

IN CASE OF EMERGENCY PLEASE CONTACT: Name:_____

Contact's Phone #: HOME (_____)_____-_____ OR CELL (_____)_____-_____

PHARMACY INFORMATION

☐ **LOCAL** PHARMACY **NAME, ADDRESS**:(Closest MAIN **CROSS** streets may suffice if address not known):

_____

PHARMACY NAME ADDRESS (**OR Main Cross Streets**) CITY PHONE #

☐ **MAIL-IN** PHARMACY **NAME** (Typically Used for **3 month** supply of medications):

_____

PHARMACY NAME PHONE # YOUR ID# (if known)

DEMOGRAPHIC INFORMATION

(Please circle for Language, Ethnicity, Race, or fill in detail as appropriate):

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER:_____

ETHNICITY: NON-HISPANIC HISPANIC/LATINO DECLINE to SPECIFY

RACE: Please **CIRCLE** appropriate group(s) from the chart below:

White	Black/African American	Hispanic/ Latino	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander
Europe	Africa	Mexico	Far East	North America	Hawaii
Middle East	Please specify which country:	Central American	South East	Central America	Guam
North Africa	_____	South American	Indian	South America	Samoa
		Puerto Rican			Pacific Islands

AUTHORIZATION AND RELEASE

♦ I hereby authorize my physician, and any physicians and/or practitioners/assistants to whom he may designate, to render treatment as deemed necessary.

♦I hereby authorize Emad Khaleeli, MD Inc to release any and all medical information necessary to process my insurance claims. I also authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information related to this claim and the expenses reported. Additionally, I authorize payment of medical and/or surgical benefits directly to Emad Khaleeli, MD Inc. This authorization shall be valid until revoked in writing. A photocopy of this original shall be valid as an original.

♦ I am aware of **the policy of presenting my CURRENT insurance card PRIOR to each visit** and that this will be the insurance processed for that date of service. *This is my responsibility*. MY failure to present an accurate insurance card may jeopardize my benefits and will forfeit any contractual obligation Emad Khaleeli, MD Inc may have with my insurance, including retroactive billing and negotiated discounts.

♦ I understand that I am responsible for any portion of the bill not covered by my insurance and I agree to pay in full at the time of service.

♦ I acknowledge that I am solely responsible for, and will be held liable for any laboratory charges not covered by my insurance, and I authorize the addition of such charges to my personal bill, for which I am solely responsible. This is particularly, but not solely, in relation to laboratory tests ordered by another of the patients' physicians/practitioners through Emad Khaleeli MD's lab work, and/or those requested by the patient him/herself, but also to those ordered by Dr. Emad Khaleeli or his staff members.

♦ I have read and I acknowledge all of the above, and hereby certify that the information is correct to the best of my knowledge. My signature indicates that I approve and grant request of this authorization.

_____ _____ _____

PATIENT SIGNATURE or Legal Representative **DATE** Relationship of Guardian, if signed by a Minor

Emad Khaleeli, M.D. ♥ **South Bay Heart Institute** ♥ **Erica Buck, N.P.**

4305 Torrance Boulevard, Suite #301, Torrance, CA 90503 ♦ Telephone: 310-793-4327 ♦ FAX: 310-793-4307

ID#_____ **PATIENT NAME**:_____ **Referring MD**:_____ **DOB**:_____

PLEASE list any ALLERGIES **AND** the REACTION experienced.

ALLERGIES: _____

PLEASE CHECK the appropriate box AND FILL-IN the amount you smoked at your PEAK…or the MOST you have ever smoked on a regular basis.

Tobacco: □ Never □Current □Former ⇨ **QUIT (/ /)**; ( )cigs or packs/day, ( )years

Alcohol: □ Never □ Current- how much: □Former ⇨ **QUIT (/ /)**

Caffeine:

Coffee: □ Regular □ Decaf Coffee- # cups per day .

Tea: □ Regular □ Decaf Tea- # cups per day .

Soda: □ Regular □ Decaf Tea- # cups per day .

Work History: .

.

Surgeries: .

.

.

MEDICATION LIST: .

	Name of Medicine	Dose (mg)	Frequency- (Once, Twice) daily

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LATE CANCELLATION AND NO-SHOW POLICY

Cancellations:

For the convenience of all of our patients and staff, Emad Khaleeli MD Inc. requires one full **BUSINESS days'** notice whenever you need to **CANCEL** an appointment. Weekends and holidays are not business days! Receiving this cancellation information in advance allows our office to schedule and serve other patients on a more timely basis. Likewise, it is considerate and appreciated. A cancellation less than 24 business hours before your appointment is unfortunately considered to be a No Show.

No Shows:

We understand the things happen and appointments may sometimes not be cancelled in advance. A No Show is an appointment that is either not cancelled more than 1 business day prior to the appointment, or one that is missed, for any reason. This subsequently requires your scheduling of another appointment which now results in 2 appointments taken with only 1 visit. Unfortunately, this contributes to impaction of our schedule and this in part contributes to the inability to get our patients in to be seen on a more timely. If you were in the hospital, a letter by **your** physician on their letterhead must be received within 1 week from the date of the No Show. This is the only way to have the No Show fee redacted from your account. You must elicit your physician and obtain this letter on your own. Currently, there is a **$50.00 charge** for each missed office visit and a **$60.00 charge** for each missed ancillary study visit such as echocardiograms, stress tests, and Holter Monitors. There is no charge for missed phlebotomy-only visits. These charges are the current charges but are subject to change without further notice. Furthermore, we reserve the right to dismiss any patient from the office of Emad Khaleeli, MD Inc. after 2 missed appointments.

We believe that a good physician/patient relationship is based on good communication and that consistent and continued care is tantamount to your health. Unfortunately, your account will be taken out of good standing until any debts or No Show fees are paid in full. Please inquire about payment arrangements if absolutely necessary.

Ongoing care with appointments and medication refills can only continue if you are a patient in good standing. Please don't wait until you are on you last pill to take care of your debts and duties as there is a processing time before you can be reinstated and prescriptions refilled, both of which are up to 1 week.

We hope this helps you understand our policies on these matters. Any questions you may have regarding these **Cancellation** and **No Show** fees should be directed to or biller first, then Dr. Emad Khaleeli

Thank you
Emad Khaleeli, MD

Signed by: _____ Date: _____

Emad Khaleeli M.D.

4305 Torrance Boulevard, Suite #301, Torrance, CA 90503
Telephone: 310-793-4327 ♦ FAX: 310-793-4307

LABORATORY WAIVER

Dr. Emad Khaleeli and his colleagues have ordered lab tests to be done. The laboratory to be used is based on the current insurance information in your chart as well as our office practices.

◆***Medicare, PPO, EPO, and Private Insurance***:

- **ANY LAB**, unless otherwise specified by your insurance carrier, for which you are responsible.

◆***Torrance Hospital IPA, Primary Care Associates***:

- **QUEST DIAGNOSTICS**, at this time, but may change, for which you are responsible to know about and go to the correct laboratory.

◆***ALL other IPA/HMO's***:

- You (your labs) are being sent to **QUEST Diagnostics, Lab Corp or any another Laboratory.** Verification of contracted lab is the patient's responsibility.

If your insurance has notified you of a specific laboratory to be used, please inform the staff, and ***please*** make sure that you use that pre-specified lab. Ultimately, you are responsible for ensuring that you, the patient, use the correct laboratory, as specified by your insurance. Failure to do so may result in the assessment of charges, for which you, the patient are solely responsible.

If you ask for any labs, other than those ordered by Dr. Emad Khaleeli, you are responsible for ensuring your other physicians forward the correct and acceptable diagnostic codes. Any charges incurred, warranted or not, will be the sole responsibility of you, the patient.

_____ _____

Type of Insurance (e.g. HMO, PPO, Private)

Insurance Company (e.g. Medicare, THIPA, PCA, etc.)

The laboratory will bill YOU if the wrong lab is used for your type of insurance. I will have to bill YOU for the laboratory if the charges are forwarded to my office instead of you being billed directly. YOUR full remittance of the bill is expected, immediately.

Please notify my Medical Assistant if there has been any change to your insurance.

Please notify the Medical Assistant if there has been any change to your insurance's contracted or pre-specified laboratories.

_____ _____

Signature/Legal Guardian or Responsible Party Date

_____

Staff (MA, MD, etc.)

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

X _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician,
Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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ACUERDO DE ARBITRAJE ENTRE MEDICO Y PACIENTE

Artículo 1: **Acuerdo de someterse a arbitraje:** Por el presente se acuerda que cualquier disputa referente a negligencia profesional, es decir, en lo que se refiera a si cualquiera de los servicios médicos efectuados bajo este acuerdo fueron innecesarios o no autorizados o fueron llevados acabo, inadecuada, neligente o incompetentemente, se determinará por medio de un arbitraje en conformidad con las leyes de California, y no por medio de un juicio o recurso a procedimiento de corte, con excepción de la revisión judicial de los procedimientos de arbitraje conforme a las leyes de California. Ambos participantes en este contrato, por el hecho de entrar a este contrato, están renunciando sus derechos constitucionales que cualquiera disputa sea decidida en corte frente a un jurado, y, en su lugar, aceptan el uso de arbitraje.

Artículo 2: **Todos los reclamos deben someterse a arbitraje:** Es la intención de los participantes que por medio de este acuerdo sea obligatorio para todos aquellos cuyos reclamos surjan o estén vinculados con el tratamiento o los servicios prestados por el médico incluyendo a cualquier cónyuge o heredero del paciente y a cualquier hijo que haya nacido o no en el momento en que ocurrió el acontecimiento que dió lugar a dicho reclamo. En el caso de una madre embarazada, el término "paciente" se referirá tanto a la madre como al bebé o los bebés que la madre espera.

Todos los reclamos por daños y perjuicios monetarios que excedan el límite de la juridición de la corte de reclamos de menor cuantia contra el médico, y los socios del médico, asociados, corporación o sociedad colectiva, y los empleados, agentes o propiedad de cualquiera de ellos, deben someterse a arbitraje incluyendo, pero no limitándose, a reclamos por pérdida de consorcio conyugal, muerte por negligencia, trastornos emocionales o daños punitivos. Que el médico haya entablado una acción judicial en cualquier corte con el fin de cobrar honorarios del paciente no significará una renúncia al derecho de someter a arbitraje cualquier reclamo por negligencia médica.

Artículo 3: **Procedimientos y Derecho Aplicable:** Se requiere que todos los participantes sean notificados por escrito en caso de una solicitud de arbitraje. Cada uno de los participantes deberá escoger un árbitro (árbitro del participante) dentro de un plazo de treinta días y los árbitros nombrados por los participantes escogerán un tercer árbitro (árbitro neutral) dentro del plazo de treinta días después de la solicitud por un árbitro neutral de cualquiera de las dos partes. Cada participante del arbitraje deberá pagar su porción prorrateada correspondiente de los costos y honorarios del árbitro neutral, además de otros gastos de arbitraje incurridos o aprobados por el árbitro neutral, excluyendo los honorarios de los abogados o de los testigos u otros gastos incurridos por una de las partes para el beneficio própio del participante. Los participantes estipulan que los árbitros tendrán la inmunidad de un oficial judicial contra la responsabilidad civil mientras está actuando en la capacidad de árbitro bajo este contrato. Esta inmunidad suplementará y no reemplazará, cualquiera otra ley, sea común o estatutoria, que se aplique.

Por medio de una petición escrita al árbitro neutral, cada uno de los participantes podrá ejercer un derecho absoluto de someter separadamente al arbitraje los asuntos de responsabilidad por daños y perjuicios.

Los participantes acceden a que toda persona o entidad que, de otra manera, sería una parte adicional oportuna en una acción judicial, pueda intervenir y participar en este arbitraje, y en caso de que tal intervención o participación ocurra, toda acción jurídica existente contra dicha persona o entidad adicional se suspenderá hasta el momento del arbitraje.

Los participantes estipulan que las disposiciones de las leyes de California aplicables a los profesionales que suministran atención médica se aplicarán a las disputas incluidas en este acuerdo de arbitraje, incluyendo, pero sin limitarse a, las Secciones 340.5 y 667.7 del Código de Procedimientos Civiles y Secciones 3333.1 y 3333.2 del Código Civil. Cualquier participante puede presentar a los árbitros una solicitud para una decisión sumaria o una adjudicación sumaria en conformidad con el Código de Procedimientos Civiles. El proceso de descubrimiento será conducido en conformidad con el Código de Procedimientos Civiles de California, Sección 1283.05, sin embargo, las deposiciones se pueden llevar acabo sin antes tener el permiso del árbitro neutral.

Artículo 4: **Disposiciones Generales:** Todos los reclamos basados en el mismo incidente, transacciones o circunstancias vinculadas deberán ser sometidas a arbitraje en el mismo procedimiento. Se renunciará al reclamo o este se anulará para siempre si (1) en la fecha en que se reciba su notificación, el reclamo, en caso de ser parte de una acción civil, fuera excluido bajo el estatuto de limitaciones de California correspondiente o (2) el reclamante no demuestra diligencia razonable en llevar adelante el reclamo de arbitraje en conformidad con los procedimientos aquí descritos. Con respecto a cualquier otro asunto que no esté estipulado expresamente en el presente, el arbitraje se regirá por las disposiciones relativas a arbitraje del Código de Procedimientos Civiles de California.

Artículo 5: **Revocación:** Este acuerdo puede revocarse por medio de notificación escrita entregada al médico dentro de un plazo de treinta (30) días de su firma y si no es revocado regirá todos los servicios médicos recibidos por el paciente. La intención de este acuerdo, es que se aplique a todos los servicios médicos efectuados en cualquier momento y por cualquiera condición.

Artículo 6: **Vigencia Retroactiva:** Si el paciente desea que este acuerdo cubra los servicios efectuados antes de la fecha de su firma (incluyendo, pero sin limitarse a, tratamiento de urgencia), el paciente deberá poner las iniciales de su nombre abajo.

Entra en vigencia en la fecha de los servicios médicos iniciales. X _____

Iniciales del Paciente o del Representante del Paciente

En caso de que cualquiera de las disposiciones del presente acuerdo de arbitraje sea declarada inválida o imposible de cumplir, las disposiciones restantes quedarán en pleno vigor y no serán afectadas por la invalidez de cualquiera de las otras disposiciones.

Entiendo que tengo el derecho de recibir una copia de este acuerdo de arbitraje. Mi firma al pie de la página representa mi acuse de recibo de una copia del acuerdo.

AVISO: AL FIRMAR ESTE CONTRATO USTED SE COMPROMETE A SOMETER CUALQUIER ASUNTO RELATIVO A NEGLIGENCIA MEDICA A UNA DECISION POR ARBITRAJE NEUTRAL Y ESTA RENUNCIANDO A SU DERECHO A UN JUICIO POR JURADO O POR JUEZ. VEA EL ARTICULO 1 DE ESTE CONTRATO.

POR: _____

Firma del Médico o Representante Autorizado Fecha

_____

Nombre del Médico, Grupo Médico o Asociación en Letra de Molde o Sello

Una copia firmada de este documento debe entregarse al paciente. El original deberá archivarse con el expediente médico del paciente.

POR: _____

Firma del Paciente o Representante del Paciente Fecha

POR: _____

Nombre del Paciente en Letra de Molde

POR: _____

Si es representante del paciente, nombre en Letra de Molde y relación al paciente.

Emad Khaleeli M.D.

4305 Torrance Boulevard, Suite #301, Torrance, CA 90503
Telephone: 310-793-4327 ♦ FAX: 310-793-4307

FINANCIAL POLICY
To be compliant with the Health Insurance Portability Act,
you *must* answer and initial the following questions:

____1. I understand that I am required to pay for all charges on the date services are rendered. Unless I **INITIAL** am covered by a PPO, EPO or government sponsored health plan in which the physician is a participating provider, and I am being seen for a service I know to be covered by my policy.

____2. I understand that Emad Khaleeli, M.D., Inc. accepts personal check, money order, or cash. If the **INITIAL** bank returns my check as unpayable, I will be charged at $35.00 service fee which will be due and payable within three days, ***along*** with the full amount of my (the patient) bill that is due.

____3. I will pay all co-pays, deductibles on the date of service. I understand that if I receive a statement in the **INITIAL** mail, the amount stating my responsibility is due in 10 days. If my account exceeds 90 days, I understand that I am in a collection status. I will pay any ancillary fees, such as No Show fee or Authorization fees within 1 week.

____4. I understand that I am ultimately responsible for my account in full, even though I have medical **INITIAL** insurance. Should there be a problem with my insurance company not paying in a timely manner or for the correct amount, I agree to pay the doctor within 90 days from the date of service and I will settle my differences/bill with my insurance company on my own.

____5. I hereby authorize payment directly to the physician or Emad Khaleeli M.D. Inc. or Erica Buck, NP, of **INITIAL** the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as valid as the original. I hereby authorize the disclosure of medical information to my stated insurance company for the purpose of obtaining payment for services rendered.

____6. I understand and hereby authorize any or all of my medical and any necessary personal information to be **INITIAL** forwarded to the billing and collection company and clearing house for the purpose of obtaining payment for services rendered.

____7. I understand and hereby authorize any and all confidential messages regarding my condition to be left on **INTIAL** my answering machine or voice mail, at home, work, cell phone, or pager, such as appointments, lab and study results and details of payment on my account.

Other than yourself, with whom may we discuss your medical condition, treatment, and medical bills?

Name:_____ Relationship:_____
Address:_____ Home #:_____Work/Cell #_____

I have read, agree and understand this financial policy.

Signature of Patient **Please Print your Name** **Date**

NOTE: The passages above relate specifically to YOU, the patient. The I and me indicate that YOU, the patient agree to the statements.

Emad Khaleeli M.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO Emad Khaleeli, MD

Date:_____, 202___

To: _____, MD

Address: _____Suite # _____,_____, CA _____.

Phone# ( )_____-_____; FAX# ( )_____-_____.

I, (**signature please**) _____, hereby authorize the requested information to be released ***to*** the office of **Dr. Emad Khaleeli** for Medical Purposes.

Patient Name: _____
D.O.B.: _____
Phone #: _____

Information being requested: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

STAFF SIGNATURE: _____DATE:_____