515 South Drive ● Suite 12
Mountain View ● California ● 94040

Main: (650) 318-3384
Toll Free: 877-ELIT-MED
Fax: (650) 318-5737

ELITE MEDICAL CENTER
PERSONALIZED PRIMARY CARE

Board Certified Internal and Geriatric Medicine Physicians

Patient Information

Patient's Name_____ _____ _____
Last First M.I.

SS# _____-_____-_____ Date of Birth ____/____/_____ Sex: M / F Marital Status **S M D W SEP**

Home Address _____Apt#_____

City _____ State _____ Zip Code _____

Home # (___) ____-_____ Work # (___) ____-_____ Cell # (___) ____-_____

Email Address _____@_____

Employer Name _____

Address: _____ City _____ State _____Zip_____

Insurance Information

Policyholder Name _____Date of Birth____/____/____SS#____-___-_____

Insurance Name_____

Policy#_____ Group#_____

Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____

Name of emergency contact_____ Phone (___) ____-_____
Relationship_____

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Inna Yaskin Inc. rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Inna Yaskin, D.O. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Dr. Inna Yaskin on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

X_____ Date____/____/____
Patient signature or guardian for the minor patient

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ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends, and Other Caregivers:
I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (circle all that apply):

Oral Communication:
Home telephone number: _____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only

Written Communication:
- ❑ OK to mail to my home address
- ❑ OK to mail to my work/office address
- ❑ OK to email to my email address at:

_____

Work Telephone Number: _____

- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only

Fax Communication: _____

- ❑ OK to fax to this number

I designate the following person listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list any time in writing.

Print Name_____ Last four digits of SS Number (required) _____
Print Name_____ Last four digits of SS Number (required) _____
Print Name_____ Last four digits of SS Number (required) _____
Print Name_____ Last four digits of SS Number (required) _____

The following person(s) are not authorized to receive my patient health information:
Print Name: _____ Print Name: _____

The Privacy Notice generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided above will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Healthcare
Operations may be permitted without prior consent.

_____	_____	_____
Name of Patient	Signature of Patient/Parent/ Guardian	Date