SEBASTIAN MD
QUYNH L. SEBASTIAN, M.D., INC. **JEFFREY L. SEBASTIAN, M.D., INC.**
TANYA KORMEILI, M.D., INC.
1260 FIFTEENTH STREET, SUITE 709
SANTA MONICA, CA 90404
(310) 917.4433 TELEPHONE
(310) 917.4432 FAX

PATIENT INFORMATION (please print) Today's Date_____

Name _____Date of Birth_____
Last *First* *M.I.*

Mailing Address_____
Street *City* *State* *Zip*

Home Phone _____Cell Phone_____ Referred by_____

E-Mail Address _____Marital Status **M S D W**

Employer_____Occupation_____Sex **M F**

How would you like our staff to address you?_____
****

RESPONSIBLE PARTY INFORMATION (if different from the patient)

Name_____Relation_____
Last *First*

Mailing Address_____
Street *City* *State* *Zip*

Home Phone_____Cell Phone_____Date of Birth_____
****

INSURANCE INFORMATION (please present insurance card and driver's license at check-in)

Primary Insurance_____Name of Policy Holder_____
Last *First*

Policy Holder (Insured) Date of Birth_____Relation to Policy Holder_____
****

EMERGENCY CONTACT

Name_____Relation_____Phone_____
Last *First*
****

PREFERRED PHARMACY

Name_____Phone_____City_____
****

May we:

Communicate pertinent information with your primary doctor? □ Yes □ No
Leave a message on your home answering machine? □ Yes □ No
Leave a message on your cell phone? □ Yes □ No
Discuss your medical condition with your family? □ Yes □ No
Thank your referral source? □ Yes □ No
Send you emails/newsletters with regarding services offered in our practice? □ Yes □ No

SEBASTIAN MD
QUYNH L. SEBASTIAN, M.D., INC. **JEFFREY L. SEBASTIAN, M.D., INC.**
TANYA KORMEILI, M.D., INC.
1260 FIFTEENTH STREET, SUITE 709
SANTA MONICA, CA 90404
(310) 917.4433 TELEPHONE
(310) 917.4432 FAX

RECEIPT OF NOTICE OF PRIVACY PRACTICES
You acknowledge that you have access to a copy of the office Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). You further acknowledge that the Notice of Privacy Practices is available at the front desk upon request.

Patient or Responsible Party Signature_____Date_____

PAYMENT POLICY
You authorize the release of medical information to your primary care or referring physician and consultants if needed and as necessary to process your insurance claims, insurance applications and prescriptions. You hereby assign your insurance benefits to be made directly to your physician for services rendered. Full payment is required for all services at the time they are rendered unless you are in a prepaid plan in which this office participates. For those patients, applicable co-payments and deductibles will be collected. This includes our consultation fee for uninsured patients. You are responsible for knowing your benefits/coverage, and are responsible for any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10 collection fee will be added to your account. You attest that the above information is accurate and that you are an eligible member. You will be financially responsible for all charges that are not covered by your insurance company. Your signature below signifies your understanding and willingness to comply with this policy.

- **You have been informed that procedures are billed and coded separately from office visits.**
- **You understand that pathology services are separate from biopsy services, and are billed accordingly. This office does not process pathology billing.**
- **You have the right to refuse any treatment.**
- **You are responsible for knowing your insurance benefits and verifying your eligibility.**
- **You are responsible for making sure you understand the risks and benefits of each procedure prior to it being rendered.**
- **You have the right to obtain a second opinion.**

Patient or Responsible Party Signature_____Date_____