Poneh Rahimi, M.D.
Gastroenterology & Hepatology
PATIENT INFORMATION SHEET

FIRST NAME:_____ **MIDDLE INT:**_____ **LAST NAME:**_____

ADDRESS:_____ **SEX: F M**

CITY: _____ **STATE:** _____ **ZIP:** _____ **MARITAL STATUS: S M W D OTHER**

HOME #_____ **WK#**_____ **CELL#**_____

BIRTHDATE:_____ **E-MAIL**_____

AGE: _____ **PREFERRED LANGUAGE:** _____ **RACE:** _____ **ETHNICITY: HISPANIC □ NON-HISPANIC □**

REFERRED BY:_____ **FAMILY DOCTOR:**_____

EMPLOYER:_____ **OCCUPATION:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

SPOUSE/NEAREST RELATIVE: _____ **PHONE:** _____

SPOUSES EMPLOYER: _____ **BIRTHDATE:** _____ **SS#**_____

EMERGENCY CONTACT: _____ **RELATION/PHONE:** _____

PRIMARY INSURANCE

COMPANY: _____

ID#_____

GROUP#_____

INSURED:_____

CO-PAY:_____

SECONDARY INSURANCE

COMPANY: _____

ID#_____

GROUP#_____

INSURED:_____

CO-PAY:_____

The undersigned hereby authorized the release of any information related 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, or 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.

1. I guarantee payment to Poneh Rahimi, M.D.

2. I authorize my insurance company(is) to pay any/all charges rendered on my behalf directly to Poneh Rahimi, M.D. I will be responsible for, and will guarantee payment on any and all charges, which may not be paid or covered by my insurance company(ies).

3. I understand payment in full may be required at the time of service (for your convenience we accept money orders, checks, cash and credit cards.) I have read and understand Dr. Rahimi cancellation fee policy for office visits as well as scheduled procedures. A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 90 days of treatment.

4. I understand if my account is submitted for collection, I will be charged a 30% fee of the balance that is transferred to the collection agency.

5. I understand the returned check fee is $50.00.

SIGNATURE_____ **DATE**_____