

**WESTSIDE MEDICAL ASSOCIATES**  
-----OF LOS ANGELES-----

99 N. LA CIENEGA BLVD, STE. 203, BEVERLY HILLS, CA 90211

NORMAN E. LEPOR, M.D., FACC, FAHA

HOOAN MADYOON, M.D., FACC, FACP

PATIENT INFORMATION			
LAST NAME	FIRST NAME	M.I.	HOME PHONE
ADDRESS	SEX F M	D.O.B	SOCIAL SECURITY
CITY, STATE	ZIP		DRIVER'S LICENSE
PATIENT'S EMPLOYER	WORK NUMBER		EMAIL

PATIENT INSURANCE INFORMATION (MUST BE COMPLETED)		
PRIMARY INSURANCE	SUBSCRIBER NAME	D.O.B.
ADDRESS	CERTIFICATE NUMBER	
NAME OF GROUP OR NUMBER	PHONE	RELATIONSHIP
SECONDARY INSURANCE	SUBSCRIBER NAME	D.O.B.
ADDRESS	CERTIFICATE NUMBER	
NAME OF GROUP OR NUMBER	PHONE	RELATIONSHIP

REFERRING PHYSICIAN INFORMATION	
NAME OF PHYSICIAN	PHONE NUMBER
NAME OF PHARMACY	PHONE NUMBER

NAME OF NEAREST RELATIVE / FRIEND NOT LIVING WITH YOU	
NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

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KAMRAN TOLUIE, M.D., FACC, FACP

**PATIENTS WITH INSURANCE**

*As a courtesy to patients with private Health Care Insurance we do complete and file claims with the appropriate insurance companies, however, all patients are kindly requested to understand that the financial responsibility for our services still remains theirs – the patients – and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, this office cannot accept responsibility for collecting the claim nor can it get involved in negotiating settlement on a disputed claim. Payment of our fees is at all times the sole responsibility of the patient.*

**PATIENTS WITH MEDICARE**

*It is the policy of this office to "accept assignment" on all claims submitted to Medicare on behalf of our patients. This means that we will file a claim with Medicare on the patient's behalf and look for payment directly from Medicare for 80% of the allowed fees and then bill the secondary insurance. Those without a secondary insurance, or if no further payment is allowed by the secondary insurance, patient will be billed for any balance allowed by Medicare. This amount is due and payable by the patient immediately upon receipt of our statement.*

**CONSENT FOR TREATMENT**

*I hereby consent to examination and treatment deemed advisable by the professional staff of Westside Cardiovascular Medical Group and I agree that all records shall remain the property of Westside Cardiovascular Medical Group. I understand that I shall be responsible for any service which is not covered in part or as a whole by insurance.*

**FINANCIAL RESPONSIBILITY**

*I, the undersigned, do hereby assume full responsibility for the payment of services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services rendered to Westside Cardiovascular Medical Group. I understand that I shall be responsible for any service which is not covered by insurance.*

*Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.*

*The undersigned certifies that he/she has read the foregoing, and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept its terms.*

**Signature** \_\_\_\_\_

*I understand I am responsible for all charges. Fees are payable as services is rendered.*

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** *I hereby authorize insurance and/or Medicare payments for services rendered to me or my dependents to be paid to Westside Cardiovascular Medical Group.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** *I hereby authorize the release of medical information necessary to process all claims to my insurance carrier.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_