SEBASTIAN MD

QUYNH L. SEBASTIAN, M.D., INC. **JEFFREY L. SEBASTIAN, M.D., INC.**

1260 FIFTEENTH STREET, SUITE 709
SANTA MONICA, CA 90404
(310) 917.4433 TELEPHONE
(310) 917.4432 FAX

Please present your insurance card and your photo identification to the receptionist. A copy will be made and your cards will be returned to you promptly.

PATIENT INFORMATION (please print) Today's Date_____

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

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

Primary Phone _____E-mail Address_____

Occupation_____Referred by_____

How would you like our staff to address you?_____

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RESPONSIBLE PARTY INFORMATION (if different from the patient)

Name_____Relation_____
Last *First*

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

Primary Phone_____Date of Birth_____

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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_____

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EMERGENCY CONTACT

Name_____Relation_____Phone_____
Last *First*

SEBASTIAN MD

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PREFERRED PHARMACY

Name_____Phone_____City_____

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May we:

Communicate pertinent information with your primary doctor?	□ 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

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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. Applicable co-payments and deductibles will be collected. You are responsible for knowing your benefits/coverage, and are responsible for any unmet deductible, non-covered services and co-payments. There is an annual administration fee of $250 per office visit, not to exceed $500 per year. This is due at the time of visit, and is non-refundable.
In the event that your account must be turned over to collections, a $20 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.**

Patient or Responsible Party Signature_____**Date**_____