BARRY J. PEARLMAN, M.D.

9001 Wilshire Blvd, Suite 200, Beverly Hills, CA 90211

PLEASE PRINT

Date	**Patient Registration**	New	Add	Change

Personal Information

Patient Name (Last, First, MI)		Address	
Social Security#		City, State	Zip Code
Date of Birth	Sex M F	Home Phone	Work Phone
Marital Status Single Married Other		Cell Phone/Beeper	
Primary Language		E-Mail Address	
Ethnicity Race Religion		Primary Care Physician	Referring Physician

Employment Information

Employment Status (Circle One)

Full Time Part Time Self Employment Not Employed Retired (Date) Student

Name of Employer/Union/Guild	Occupation
Employer Address	Employer City, State, ZIP

Additional Information

Driver's License State/ID	Mother's Maiden Name	Place of Birth City & State	Pharmacy
Driver License ID#/ID#	Patient's Maiden Name		Pharmacy Phone & Fax#

Emergency Contact

Name	Relationship	Home Phone	Work Phone
Address, City	State, Zip Code	Legal Guardian Yes No	Cell Phone

Guarantor Information

Name of Person who is Financially Responsible for the Patient		Relation to Patient
Employer	Social Security Number	Date of Birth

Please Continue on Back

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Insurance Information			
Primary Insurance PPO/POS/HMO		**Subscriber ID#**	**Phone Number**
Member Effective Date	**Relationship to Subscriber**	**Group#**	**Group Name**
Primary Insurance Claim Address			
Secondary Insurance PPO/POS/HMO		**Subscriber ID#**	**Phone Number**
Secondary Insurance Claim Address			
Member Effective Date	**Relationship to Subscriber**	**Group#**	**Group Name**

Insurance Information (Medicare Patients Only)			
Subscriber ID#	**Relationship to Subscriber**	**Part A Eff Date**	**Part B Eff Date**
Have you assigned your benefits to a HMO? Yes No		**(If Yes) Medical Group Name**	

AUTHORIZATION TO PAY

I,_____ __, hereby authorize _____ to pay directly to Barry J. Pearlman, M.D. the surgical and or medical benefits, if any, otherwise payable for his services as described on my insurance form hereof, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance company.

DATE: _____ SIGNATURE: _____

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Notice of Privacy Policy

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We shall only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of US or Foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instances, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your information to only certain individuals involved in

your care or the care, such as family members and friends. We are not required to agree to your request, however, if we do not agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to the Office Manager.
4. You may ask to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept for by our practice. To request an amendment, your request must be in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Policies. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your practice rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policy, please contact the Office Manager.

I hereby acknowledge that I have been presented with a copy of Barry j. Pearlman, M.D., Notice of Privacy Practice.

Signature_____

Print Name_____

Date_____

Patient record of disclosure

In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individuals' office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)
HOME TELEPHONE_____
_____ Okay to leave message with detailed information
_____ Leave message with a call back number

WORK TELEPHONE_____
_____ Okay to leave message with detailed information
_____ Leave message with a call back number

CELLULAR TELEPHONE_____
_____ Okay to leave message with detailed information
_____ Leave message with a call back number

WRITTEN COMMUNICATION_____
_____ Okay to mail to my home address
_____ Okay to mail to my work/ office address
_____ Okay to fax to this number _____

If you would like to give our office permission to discuss your protected health information and your account information with your spouse or any other individual, please list the names of those individuals here:

_____
_____
_____
_____

OTHER INSTRUCTIONS-

_____
_____
_____

Patient Signature_____Date_____

Print Name_____ Date of Birth _____

BARRY J. PEARLMAN, M.D.
9001 WILSHIRE BLVD STE # 200
BEVERLY HILLS, CA 90211
PHONE# (310) 273-8144 FAX (310) 271-3793

RECORDS RELEASE AUTHORIZATION

TO _____

DOCTOR OR HOSPITAL

_____

ADDRESS **PHONE NO.** **FAX NO.**

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO: DR. BARRY J. PEARLMAN:

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/ OR TREATMENT DURING THE PERIOD FROM

_____TO_____

NAME_____ D.O.B._____

ADDRESS_____

SSN#_____

SIGNATURE_____ DATE_____

WITNESS_____

(IF RELATIVE STATE RELATIONSHIP)